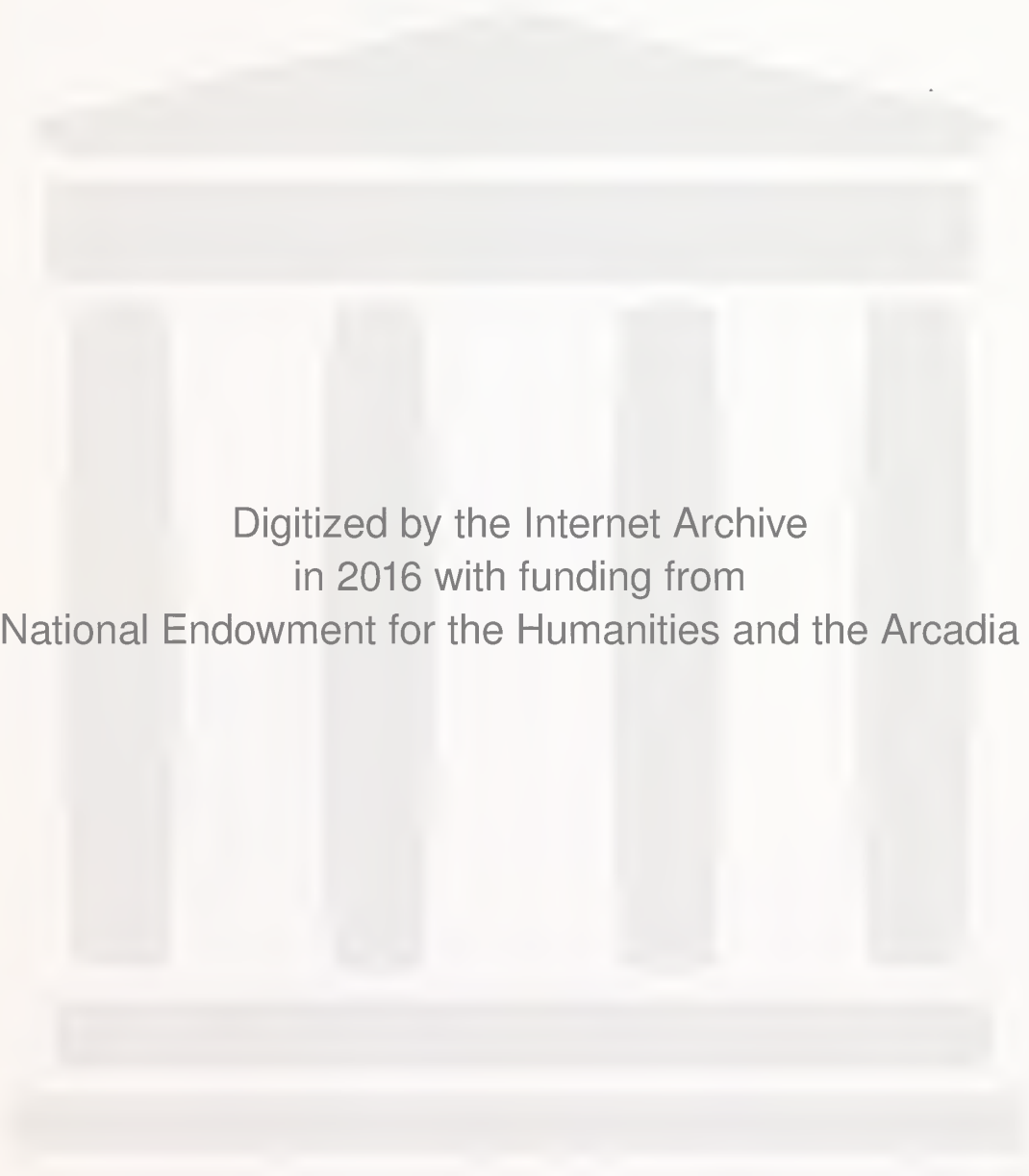


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IN THIS ISSUE:

- New Method for Control of Immunologic Problems From the Rh-Incompatible Pregnancy—Charles A. White, M.D.
- Metastasizing Thyroid Cancer Ten Years After Radioactive Iodine Treatment for Hyperthyroidism—Frederic W. Stamler, M.D., Richard D. Liechty, M.D., and Elmer L. DeGowin, M.D.
- Oculoglandular Tularemia: A Case Report—Rodney A. Anderson, M.D.
- Rupture of Left Subclavian Artery and Fatal Hemorrhage in Patient With Multiple Neurofibromatosis—Robert M. Cardelli, M.D., and William F. McCormick, M.D.
- Audiovisual Techniques in the Teaching of Anatomy: Television—W. K. Metcalf, M.D., D. J. Moffatt, M.B., Ch.B., D. A. Griffiths, M.B., Ch.B., and A. W. Jacobs, M.A.



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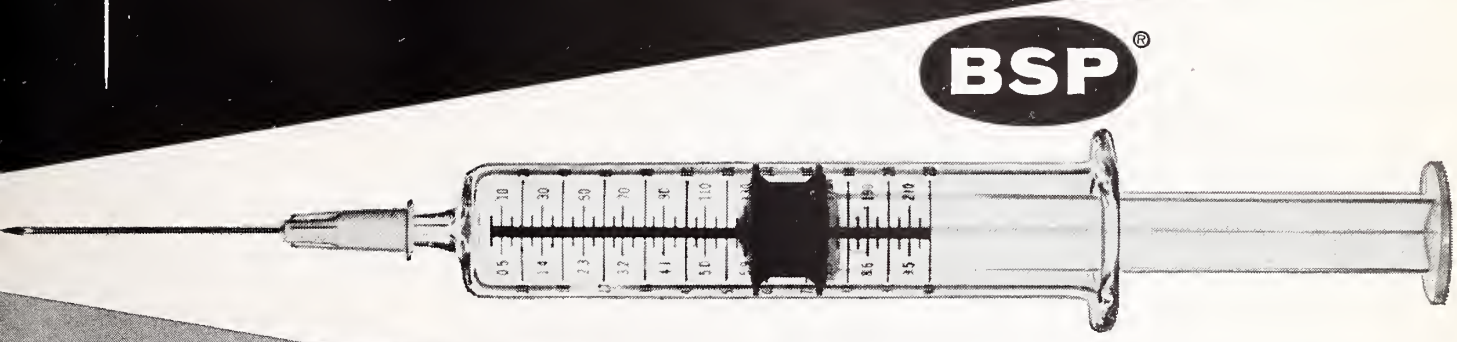
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Vol. LX JANUARY, 1970 No. 1

CONTENTS

SCIENTIFIC ARTICLES

New Method for Control of Immunologic Problems From the Rh-Incompatible Pregnancy
Charles A. White, M.D. 13

Metastasizing Thyroid Cancer Ten Years After Radioactive Iodine Treatment for Hyperthyroidism
Frederic W. Stamler, M.D., Richard D. Liechty, M.D., and Elmer L. DeGowin, M.D. 16

Oculoglandular Tularemia: A Case Report
Rodney A. Anderson, M.D. 21

Rupture of Left Subclavian Artery and Fatal Hemorrhage in Patient With Multiple Neurofibromatosis
Robert M. Cardelli, M.D., and William F. McCormick 24

Audiovisual Techniques in the Teaching of Anatomy: Television
W. K. Metcalf, M.D., D. J. Moffatt, M.B., Ch.B., D. A. Griffiths, M.B., Ch.B., and A. W. Jacobs, M.A. 26

EDITORIALS

An Ideal Parent-Child Relationship 33

Ave Atque Vale! 33

Sex and the Single Student 34

Let's Not Be Sentimental About Alcoholics . . . 35

Control of Bleeding in Hemophilic Patients . . . 36

SPECIAL DEPARTMENTS

The Month in Washington 7

President's Page 32

Coming Meetings 37

In the Public Interest facing page 38

Journal Book Shelf 39

Iowa Chapter of the American Academy of General Practice 41

Information From the Iowa Heart Association: "Prosthetic Replacement of the Mitral Valve: An Assessment of the Clinical and Hemodynamic Results of Operation"—Andrew G. Morrow, M.D. 42

Iowa Association of Medical Assistants 46

The Doctor's Business 50

State Department of Health 53

Woman's Auxiliary News 55

Personals 59

Deaths 66

MISCELLANEOUS

AMA Film on Sex Education 31

Psychiatric and Legal Aspects of Drug Use and Abuse 31

Doctors' Fees Just Ten Per Cent of Medicaid Costs in Minnesota 44

Sales and Use Taxes Payable by Physicians . . 48

Statement Regarding Rubella 51

Pediatrics Academy Calls for Local Sports Medicine Councils 54

"Adverse Reaction" Information Sought From Hospitals 54

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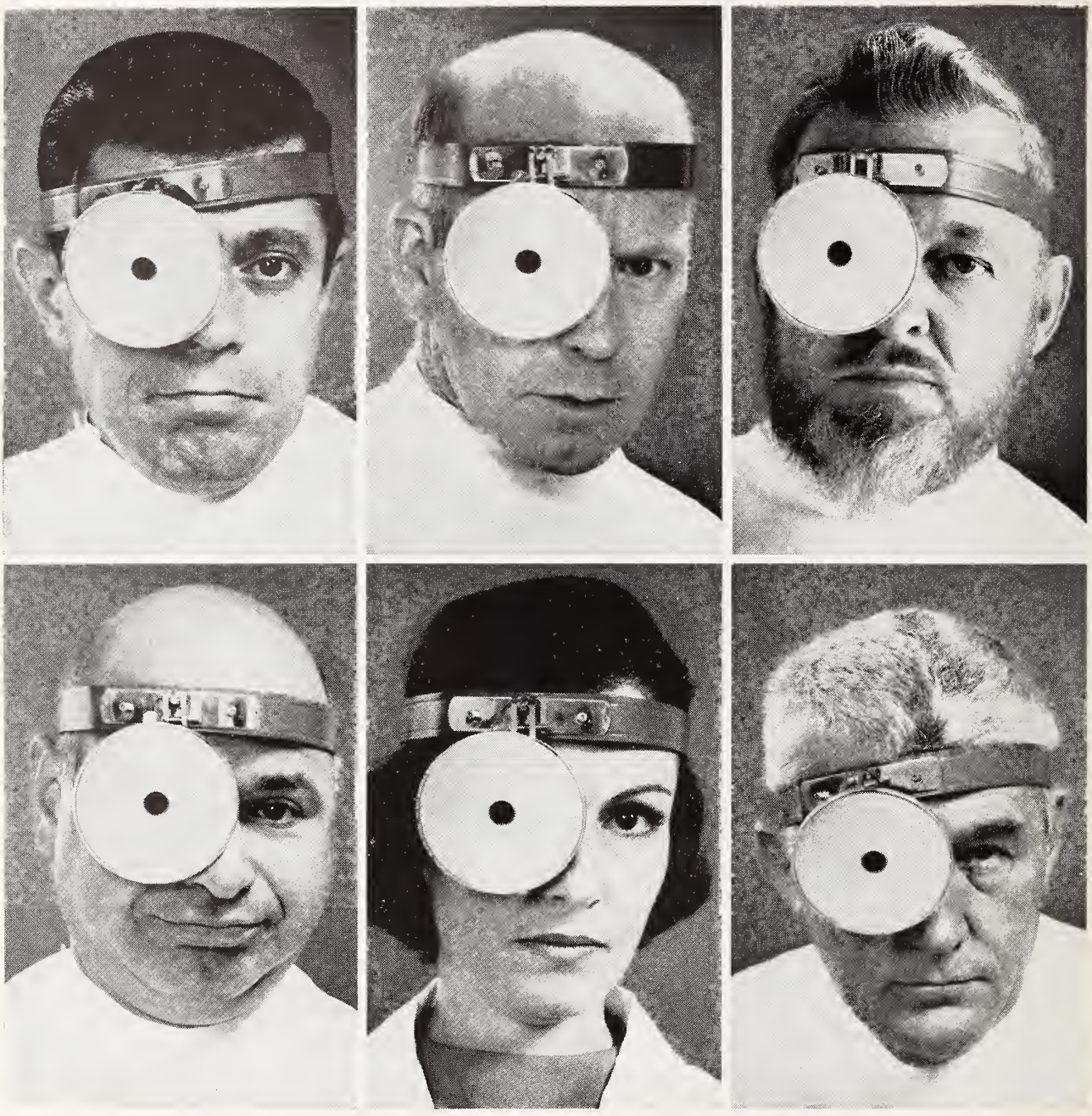
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You might also say that all otolaryngologists aren't alike, either.





The Month in Washington

Washington—A Senate subcommittee said that the number of medical malpractice suits probably will increase and that "the situation threatens to become a national crisis."

Sen. Abraham Ribicoff (D., Conn.), chairman of the Subcommittee on Executive Reorganization which has been reviewing the federal role in the nation's health care problems for nearly two years, reported eight conclusions after an extensive staff study. They are:

"1. The number of malpractice suits and claims is rising sharply in certain regions of the country. The size of judgments and settlements is increasing rapidly.

"2. Most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority have proved justifiable. These suits are the indirect result of a deterioration of the traditional physician-patient relationship.

"3. The publicity given to higher malpractice judgments and settlements, based frequently on new legal precedents, is likely to trigger increasing litigation in other states. The situation threatens to become a national crisis.

"4. Already, higher judgments and settlements are having the following direct results:

(a) Companies providing malpractice insurance are increasing the cost of coverage.

(b) These costs—in the form of higher charges—are being passed on to patients, their health care insurance companies, and federal health-care programs.

"5. The rising number of malpractice suits is forcing physicians to practice what they call defensive medicine, viewing each patient as a potential malpractice claimant. Physicians often order excessive diagnostic procedures for patients, thereby increasing the cost of care. Moreover, they are declining to perform other procedures which in themselves may entail some risk of patient injury.

"6. At present, it appears that no one affected by the rise in malpractice suits and claims has been able to deal with this problem in a manner that promises to alleviate this situation.

"7. The lion's share of the total cost to the insurance companies of malpractice suits and claims goes to the legal community.

"8. There is a definite federal role in the malpractice problem."

Specialists listed as having "a greater potential exposure to malpractice suits" were orthopedic surgeons, general surgeons, neurosurgeons, anesthesiologists, and obstetricians and gynecologists.

The 1,150-page report included responses to inquiries sent to the American Medical Association, the American Hospital Association, lawyers and malpractice insurance companies.

If the situation continues to worsen, the report said, the federal government "may have to consider . . . a reinsurance pool to which it would contribute."

If the federal government moves into the malpractice area, the report said, it also should consider: "whether medical or surgical injury to a patient is a community responsibility and therefore is compensable by the community;

" . . . whether it must provide legal aid to the poor to help them seek redress from personal medical or surgical injury.

" . . . whether it will insist upon the creation of more effective regulatory devices over health professionals and health facilities to assure that those who are providing care are competent to do so."

* * *

A special task force recommended that the federal government experiment with different ways of paying physicians under Medicare and Medicaid.

In the first of a series of reports on Medicaid, the task force which HEW Secretary Robert H. Finch appointed last July, said: "HEW should actively program experiments for incentive reimbursement under Medicare and Medicaid, with new emphasis on experiments in payment methods for physicians as the key generators of health services. In addition to experiments in institutional reimbursement, other experiments could emphasize compensation to groups of practitioners, using modified approaches to capitation with built-in controls on quality and costs."

The report said that states also should be made aware of options now available under present laws and regulations, in addition to the individual fee-for-service basis for payments to physicians. The report listed "contract payments with quality controls, case-average methods, and fee for time."

The task force recommended that Medicaid funds be used to finance group practice, neighborhood health clinics and home health-care programs, particularly in ghettos and other low-income areas.

The recommendation was the core of a program designed "to effect changes and improvements in the health care delivery system" of the nation.

"Bringing about needed major changes in the organization and delivery of health services is a long-range objective requiring national commitment and establishment of national policy and

(Continued on page 10)

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The Month in Washington

(Continued from page 7)

priorities," the task force said in the first of a series of reports. "For the short-range, we are recommending certain actions which could bring about some improvements and which are consistent with long-range objectives."

For the short-range, it was recommended that five per cent of federal Medicaid funds be earmarked for state "development and improvement of health care services and resources." Consideration also should be given to such use of Medicare funds, the report said.

The federal government was urged to take a more positive leadership role in the Medicare program, first by improving its own administrative machinery, and then by getting the states to make their management functions more efficient.

Other recommendations of the task force included:

—Denying federal Medicaid funds to chiropractors and naturopaths.

—Requiring uniform provisions and unified state standard-setting, certification, and consultation functions with respect to providers of service under both Medicaid and Medicare.

—Establishing eligibility for Medicaid benefits by permitting an applicant to fill out a simple declaration form.

—Requiring "profiles at the state level of vendors and recipients of service, and criteria against which to screen claims to identify patterns which appear to deviate from desirable and/or usual behavior."

The American Medical Association urged Congress to give top priority to appropriations that will help increase the number of physicians.

Testifying before a Senate appropriations subcommittee, Dr. C. H. William Ruhe, director of the AMA's Division of Medical Education, said, "Medical education should be supported financially as fully as possible to meet the pressing need which exists today for an increased number of physicians."

"We believe," he said, "that in any appropriation priorities established for all government programs, those which affect health care should be given primary consideration. Further, because of the special need . . . for more physicians, we urge that appropriations relevant to the production of physicians be given first priority."

Concerning decreases in the Administration budget in support of research and training grants, fellowships, library grants and research facility construction, the AMA spokesman said:

"It is difficult to estimate the effect these reductions will have upon efforts to increase physician production, but there is concern among many medical educators that the growth in medical school enrollments will be inhibited. We believe that this effect should be watched closely and corrective measures instituted promptly if physician production is impaired."

The AMA joined the Student American Medical Association and the Association of American Medical Colleges in a joint statement which said: "An increase in the appropriation for the Health Professions Student Loan Program is crucial."

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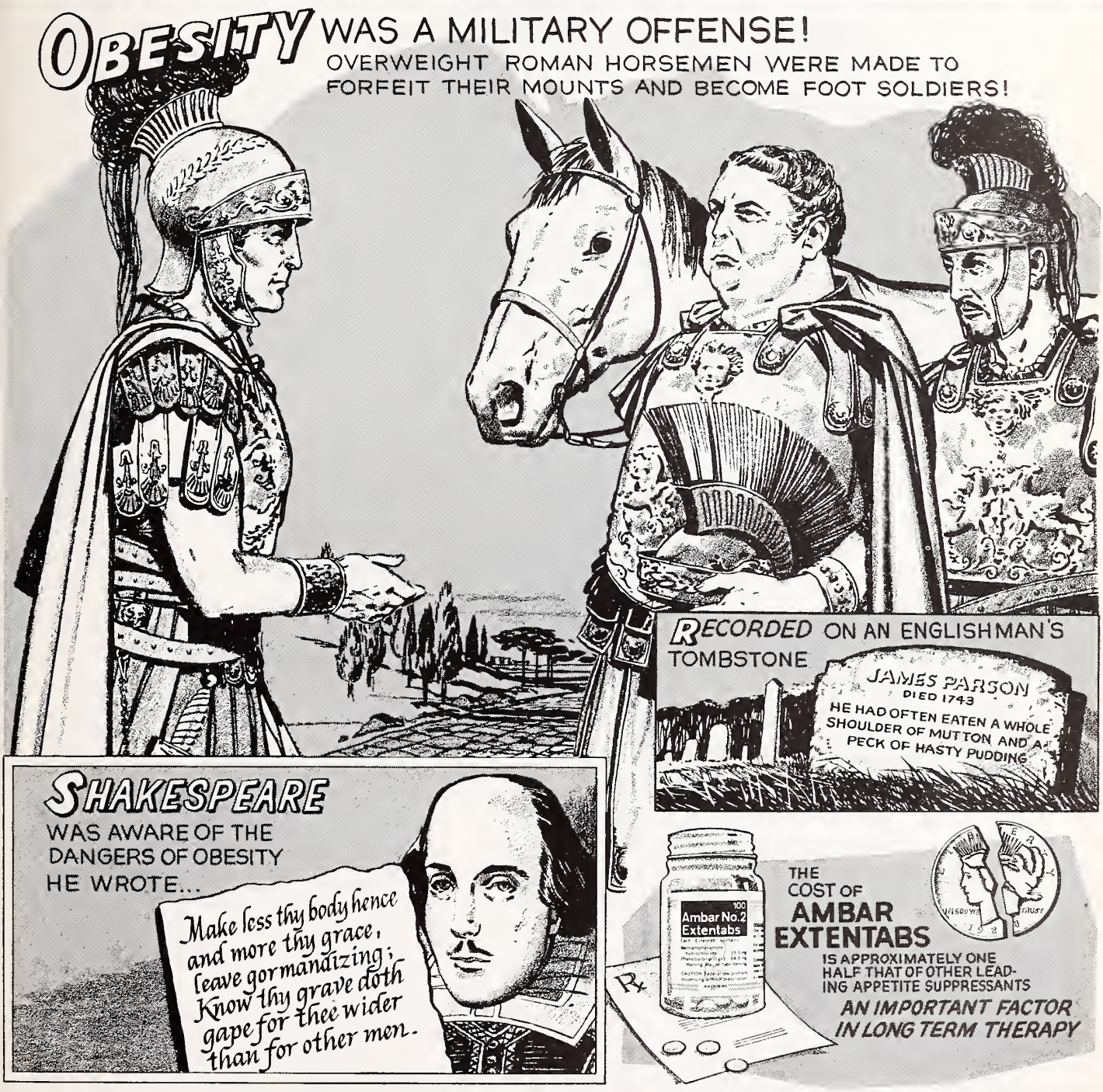
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Scientific Articles

New Method for Control of Immunologic Problems From the Rh-Incompatible Pregnancy

CHARLES A. WHITE, M.D.
Iowa City

From the recognition of the pathogenesis of Rh-isosensitization, by Levine in 1941, to the availability of prevention by antibody-mediated immune suppression in 1966, we have come far within a generation.

First, a brief review of erythroblastosis caused by Rh sensitization as it affects perinatal mortality. In 1941, when the etiology of Rh isosensitization was recognized, perinatal mortality in erythroblastotic infants was approximately 50 per cent. That figure was reduced to approximately 25 per cent beginning in 1948, with the advent of neonatal exchange transfusions. Then in 1955 the regimen of selective preterm induction of labor reduced the perinatal wastage to approximately 15 per cent. Beginning in 1961, analysis of amniotic fluid obtained by percutaneous amniocentesis permitted a much more accurate assessment of the severity of erythroblastosis for a particular pregnancy, and helped to reduce the perinatal loss to approximately 10 per cent. Then, beginning in 1963, intrauterine fetal transfusions for fetuses too severely involved too early in pregnancy to permit preterm delivery has promised to diminish fetal wastage to as low as 5 per cent. Most recently, the administering of anti-Rh immunoglobulin to non-sensitized Rh-negative women may eventually permit the near-eradication of erythroblastosis associated with Rh isoimmunization.

Levine and co-workers showed that this hemolytic disease occurred only after an Rh-negative mother had become immunized against the fetal Rh factor described by Landsteiner and Wiener. Since the Rh antigen exists only on erythrocytes of human beings and other primates, there are three ways in which a mother can receive the necessary antigenic stimulus: first, during her own fetal life, from the Rh-positive red cells of *her* mother, and that must be a very rare phenomenon; second, by a previous transfusion or intramuscular injection of Rh-positive blood—an accident which still occasionally occurs; or third, from a previous Rh-positive pregnancy. The last of these accounts for the majority of cases.

The Rh-positive baby that initiates immunization escapes harm because maternal antibodies rarely appear until some four to six weeks after delivery. However many mothers do not reveal their immune state until a subsequent Rh-positive pregnancy. The appearance of antibody is almost never observed during the first Rh-positive pregnancy, but is restricted to the second or a later pregnancy.

Dr. White, an associate professor of obstetrics and gynecology, made this presentation at a Program on Human Transplantation, in Iowa City on May 10, 1969.

It is an important concept that the first *affected* pregnancy is always the first Rh-positive pregnancy following the *priming* pregnancy. The first *affected* pregnancy is characterized by a low level or an absence of anti-Rh early in that gestation, and later in most cases a rise in titer occurring anytime between 18 weeks' gestation and a few days after delivery. The onset of the *secondary* response is almost certainly related to that time during pregnancy when fetal-maternal erythrocyte transfer occurs.

The idea that after a pregnancy has initiated an immune response, the next Rh-positive pregnancy will inevitably be the first one affected is due largely to the classic studies of Nevanlinna. The belief that initial sensitization to Rh occurs during the first affected pregnancy is erroneous. If that were true, the present program of applying immunosuppression by passively-given Rh antibodies in the early puerperium would be doomed to failure.[1]

THE ANTIGENICITY OF $Rh_0(D)$

Rh is by far the most immunogenic of the intragroup red-cell antigens. Wiener immunized 75 per cent of Rh-negative individuals by means of repeated injections with 2 to 3 ml. of Rh-positive blood, and Zipursky immunized 26 per cent of volunteers with two injections of 0.1 ml. of fetal Rh-positive blood. Those studies indicate that the risk of immunization is related to the size of the antigen dose.

Next, a few comments about the contrast between primary and secondary Rh responses. Following the injection of Rh-positive blood into Rh-negative recipients, several weeks usually elapse before antibody is first detected in the sera of immunized individuals. The first antibody detected is usually of the 7S class; 19S occurs less frequently. But not all individuals who become immunized to the injection of Rh-positive cells show readily detectable antibody. In about 25 to 50 per cent of the immunized groups, the *primary* response occurs without anti-Rh becoming detectable in the circulation by the usual methods. However 100 per cent of individuals once sensitized can be stimulated to make a secondary immune response if they are exposed to minute doses of Rh-positive blood. This secondary response is characterized by a rising titer occurring within two to seven days after the new antigenic challenge.

PREGNANCY AND Rh IMMUNIZATION

There is little doubt that a pulse of fetal red cells is likely to enter the maternal circulation at delivery, and the average fetal bleed may be on the order of 0.1 to 0.2 ml.

Rh-hemolytic disease appears to violate the fairly universal law of nature that a mother does not initiate an immune response against, or reject, her fetus, though it is, in effect, a foreign homograft. Obviously, powerful but ill-understood mechanisms operate to prevent the foreign antigens from activating the homograft-rejection mechanism. Pregnancy probably does render the host less susceptible to a primary immune response, and results in a lessened sensitivity to the Rh antigen. But this relative degree of immunologic inertia does not apply to an already sensitized individual, for the secondary response is unaffected by pregnancy. Nor does it persist when pregnancy has terminated, since Rh-negative women show normal responsiveness to the Rh-positive fetal cells that survive in their circulations after parturition. Were it not for the fact that fetal red cells survive for long periods in the maternal circulation after delivery, it is likely that the risk of Rh immunization would be the same as the 0.1 per cent that is seen in Rh-negative primigravidas during pregnancy.

Now regarding antibody-mediated suppression. In 1909 Smith noted that mixtures of diphtheria toxins and antitoxins prepared with marked antibody excess failed to immunize the recipient animals. Since then many others have shown that passive antibody is equally immunosuppressive when given before or just after antigen injection, or when mixed with the antigen. Antigen-mediated immune suppression is a phenomenon that appears to apply to all antigen-antibody systems and to all mammals, and is absolute, provided that an adequate dose of high-affinity antibody is administered.

The exact mechanisms by which passively-given antibody prevents a *primary* immune response are unknown, but they are related to the combining of them with antigen *in vivo*. The simplest explanation is that antibody-binding renders the antigen determinates sterically unavailable to the antibody-forming apparatus. Whether or not the antigen is in the form of RNA-antigen complex, and whether antibody prevents contact between the antigen and the lymphocyte membrane, or interrupts the proc-

essing by appropriate macrophages has not been determined.[4]

In this country, in 1959, Pollack, Gorman and Freda set out to exploit the phenomenon of antibody-mediated immune suppression to prevent the sensitization of Rh-negative mothers. They fractionated and obtained gamma globulin from plasma containing anti-Rh, as a means of getting a convenient, potent and reproducible preparation known to be free of serum hepatitis. Their original study in male volunteers clearly demonstrated that an adequate dosage of 7S anti-Rh could be used to suppress a primary immune response completely. In addition, since no unwanted side effects were seen, it was thought safe to begin clinical trials with it in mothers.[2, 3]

Criteria for admission to the trials of Rh-immune globulin (now called RhoGAM*) were as follows: The mother must be Rh-negative and previously unsensitized to the Rh antigen, as demonstrated by an absence of anti-Rh in her serum prior to and at the time of delivery. In addition, her infant must be Rh-positive, must be ABO-compatible, and must have a negative direct Coombs reaction.

RESULTS OF THE CLINICAL TRIALS

As shown in Table 1, nearly 5,500 women have undergone RhoGAM clinical trials in this and other countries.[5] Complete information is available on over 4,000 patients. Of 2,880 who received RhoGAM within 72 hours after delivery, only three, or 0.1 per cent, have demonstrated anti-Rh antibodies six months postpartum. By comparison, 84 of 1,200 controls, or 7 per cent, have demonstrated antibodies.

Of course the most critical data involve those 378 patients (Table 2) who have subsequently delivered Rh-positive infants. Of the 228 who had RhoGAM prophylaxis at the time of the preceding pregnancy, only one (0.4 per cent) had an anti-Rh titer. This is a very encouraging finding when compared to 21 out of 148 controls (14.1 per cent). This 14 per cent incidence is twice that observed for six months following the first pregnancy, and reflects the anamnestic response to the subsequent pulse of fetal erythrocytes during the next pregnancy. Thus it appears that initial sensitization causes only half of the women to produce antibodies in amounts above the threshold of detectability.

* Ortho Diagnostics, Raritan, New Jersey.

CONCLUSION

Since the large pool of already sensitized Rh-negative women will contribute cases of hemolytic disease of the newborn until they have passed through the childbearing period, the effect of Rh prophylaxis on perinatal mortality and morbidity will be gradual. But the present availability of RhoGAM should permit our reducing erythroblastosis to the vanishing point within the next generation.

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TABLE 1

RhoGAM CLINICAL STUDIES
PATIENTS FOLLOWED 6 MONTHS POSTPARTUM

	No Anti Rh	Anti Rh	Data Incomplete	Lost to Follow-up	Total
Treated	2877	3	636	294	3810
Control	1116	84	139	321	1660
Total	3993	87	775	615	5470
	3/2880 = 0.1%		84/1200 = 7.0%		

TABLE 2

RhoGAM CLINICAL STUDIES
SUBSEQUENT Rh_0 (D) DELIVERIES

	No Anti Rh_0 (D)	Anti Rh_0 (D)	Total
Treated	228	1	229
Control	127	21	148
Total	355	22	377
	21/148 = 14.1%	1/229 = 0.4%	

Metastasizing Thyroid Cancer Ten Years After Radioactive Iodine Treatment for Hyperthyroidism

FREDERIC W. STAMLER, M.D.,
RICHARD D. LIECHTY, M.D., and
ELMER L. DeGOWIN, M.D.
Iowa City

Thyroid carcinoma with cervical lymph node metastasis was found in a woman 35 years of age nearly 10 years after I^{131} therapy for hyperthyroidism. She had become euthyroid after a single treatment and had remained asymptomatic without replacement therapy for over nine years when a palpable thyroid nodule was first noted.

Her case is contrasted with that of a second patient who was given I^{131}, became hypothyroid, was maintained on thyroid replacement therapy and was found to have multiple atypical benign thyroid nodules 10 years later.

The second case appears to refute the contention that thyroid tumors do not occur following radiation therapy sufficient to cause hypothyroidism. A survey of reported cases, however, indicates that both benign and malignant thyroid neoplasms occur rarely in adults after radiation therapy, and that I^{131} offers a relatively safe therapy for hyperthyroidism.

A 35-YEAR-OLD WOMAN developed thyroid carcinoma nine years and eight months after treatment with I^{131} for hyperthyroidism. To our knowledge, she is the sixth patient with microscopically proved thyroid cancer following I^{131} therapy.

CASE HISTORY

On May 14, 1958, the patient noted a 30 lb. weight loss, increased appetite, goiter and nervousness. Her physical findings suggested hyperthyroidism. Laboratory tests revealed a basal metabolism rate of 30 per cent, a protein-bound iodine of 7.7 per cent, and thyroidal uptake of I^{131} 12 per cent in four hours and 23 per cent in 24 hours.

On June 26, 1958, her symptoms and signs had progressed. Her I^{131} uptake was 32 per cent in four hours and 60 per cent in 24 hours, confirming the initial impression of hyperthyroidism. She received 3.4 millicuries of I^{131}, with an uptake of 20 per cent in 24 hours. That was her only treatment with I^{131}.

In October, 1958, she was clinically euthyroid. Laboratory procedures showed a BMR of 14 per cent, protein-bound iodine 6.8 mcg. per cent, and I^{131} uptake 15 per cent in four hours and 24 per cent in 24 hours.

In July, 1959, she was clinically euthyroid. The laboratory test results were BMR 4 per cent, PBI 6.5 mcg. per cent, and I^{131} uptake 13 per cent in four hours and 27 per cent in 24 hours. Subsequently she was under the care of her hometown physician.

In February, 1968, she was again referred to University Hospitals (Dr. DeGowin) because of a firm nodule 1.5 cm. in diameter in the right thyroid lobe. She appeared euthyroid. We noted a hard node in the left upper neck in addition to the firm nodule in the right thyroid lobe.

Surgical exploration on March 4, 1968 revealed a benign cystic lesion of the right lobe. The firm node in the left neck and the left lobe of the thyroid contained thyroid cancer diagnosed by frozen sections. Total thyroidectomy with excision of lymph nodes in the left neck was performed. The patient was discharged on the seventh hospital day.

Pathologic findings. The left thyroid lobe

Dr. Stamler is a professor of pathology, Dr. Liechty is an associate professor of surgery, and Dr. DeGowin is an emeritus professor of internal medicine at the U. of I. College of Medicine. Requests for reprints should be addressed to Dr. Stamler.

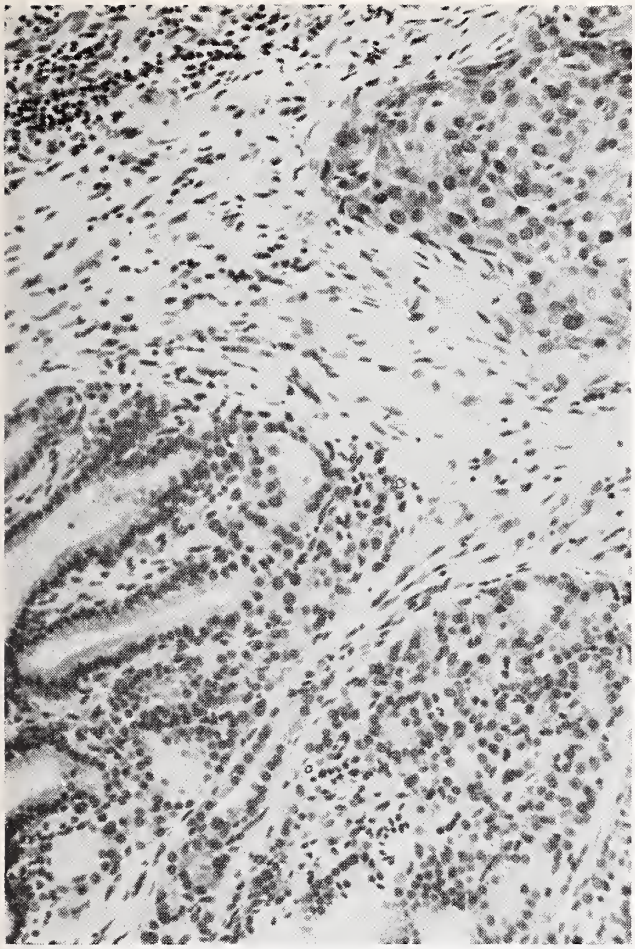


Figure 1. Thyroid carcinoma showing papillary and follicular differentiation as well as solidly cellular invasive neoplasm. Hematoxylin and eosin ×150.

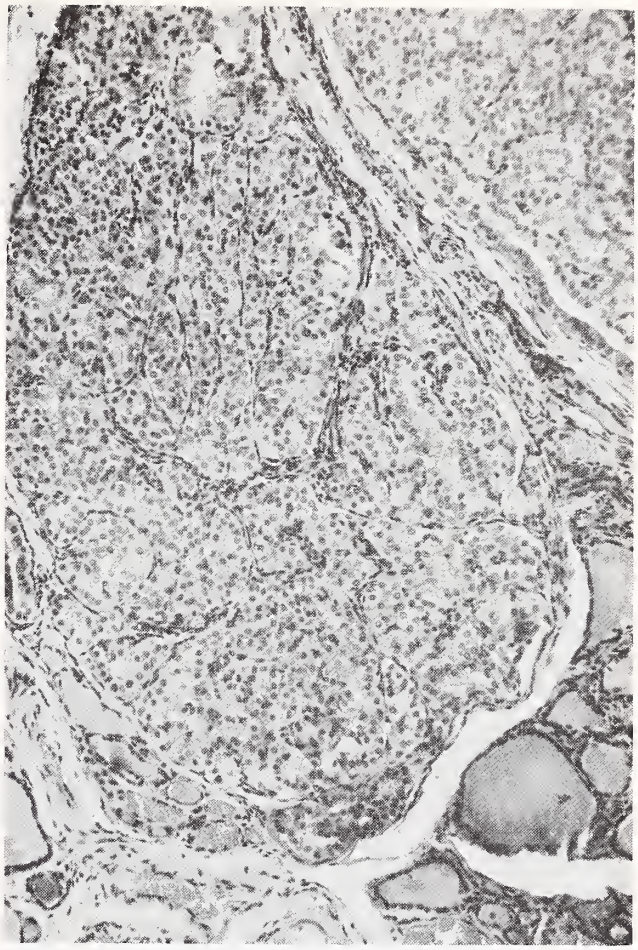


Figure 2. Carcinomatous nodules of trabecular pattern interspersed with relatively normal thyroid tissue. H&E ×125.

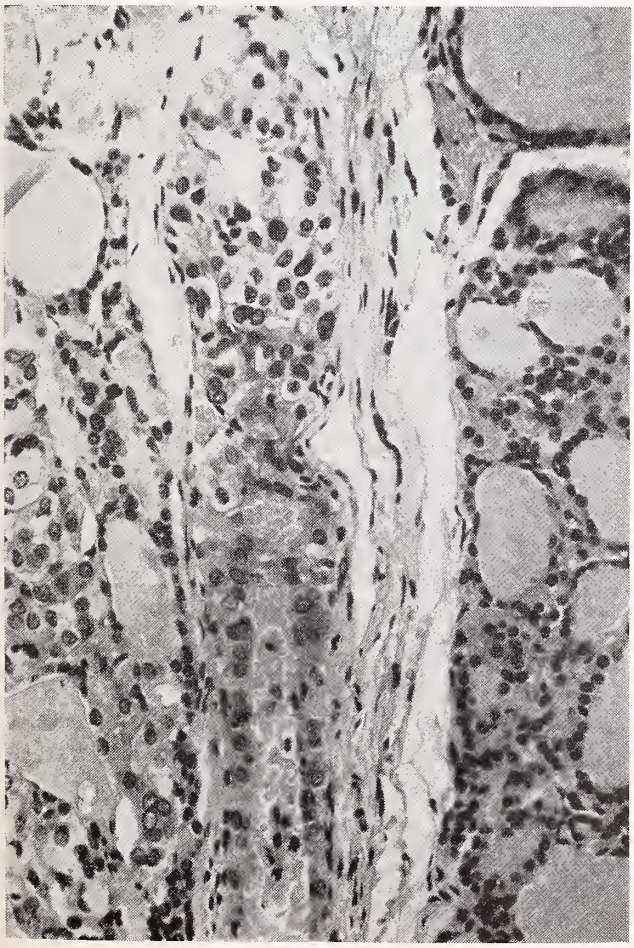


Figure 3. Invasion by carcinoma of tangentially sectioned vein in middle of photograph. Tumor fills vein at the top, and lines the vein lumen at the bottom. H&E ×300.

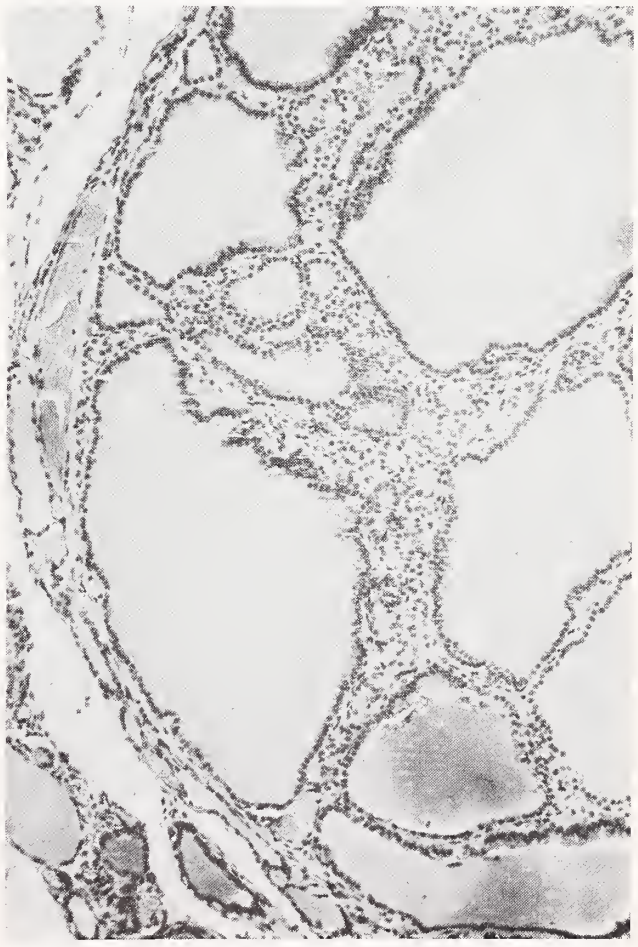


Figure 4. Hyperplastic colloid nodule. Slight papillation of columnar epithelium lining enlarged follicles, with no appearance of malignancy. H&E ×125.

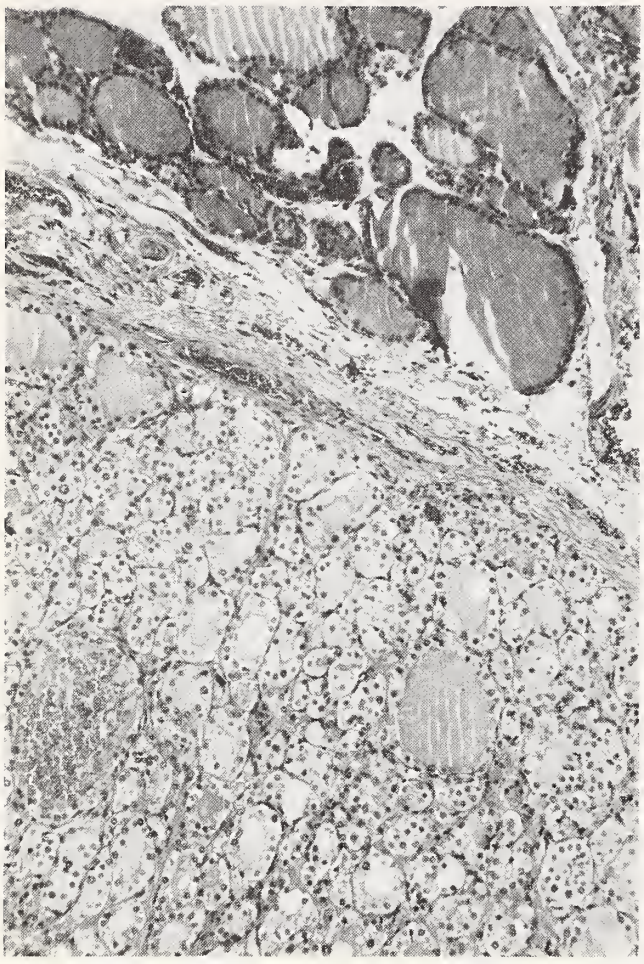


Figure 5. Encapsulated fetal adenomatous nodule of benign appearance. Normal thyroid adjacent to nodule. H&E ×125.



Figure 6. Fibrotic wall of cyst, left lobe of thyroid. Hemorrhagic debris and fragments of degenerating thyroid tissue comprise cyst contents. H&E ×80.

weighed 14.5 Gm., and the right lobe, including the cystic degenerated nodule, weighed approximately 10 Gm. Both lobes contained numerous small nodules with multiple foci of carcinoma. The neoplasm was of a mixed type, with areas of papillary and follicular differentiation, as well as solid cellular foci growing invasively (Figure 1). In some portions of the gland, nodules of predominantly trabecular carcinoma were interspersed with normal tissue (Figure 2). Lymphatic permeation and vascular invasion were evident (Figure 3). Hyperplastic colloid nodules (Figure 4) and fetal adenomata were also present (Figure 5). Much of the intervening thyroid tissue was essentially normal; there was no evidence of the atrophy, interstitial fibrosis, lymphocytic infiltrate and cellular atypism which had been noted in the thyroid glands of other patients months or years after radioiodine therapy.[1] The cystic mass in the right lobe contained degenerating thyroid remnants and hemorrhagic debris surrounded by a fibrotic capsule including hemosiderin and foci of dystrophic calcification (Figure 6).

The left cervical lymph node which was observed clinically was extensively involved by metastatic foci (Figure 7) resembling the primary neoplasm in that well-differentiated follicular and papillary components were closely associated (Figure 8). All of the other lymph nodes which were removed at operation were free from neoplastic involvement.

DISCUSSION

Of the previously reported patients who developed thyroid carcinoma after I^{131} therapy for thyrotoxicosis, two were children. In one child the tumor was diagnosed as "invasive papilloma with capsular invasion," and nearly five years after operation the patient had no evidence of recurrence.[2] The second child was diagnosed as having "papillary carcinoma with capsular invasion" approximately 29 months after I^{131} therapy, propylthiouracil and Lugol's solution for thyrotoxicosis. In early childhood

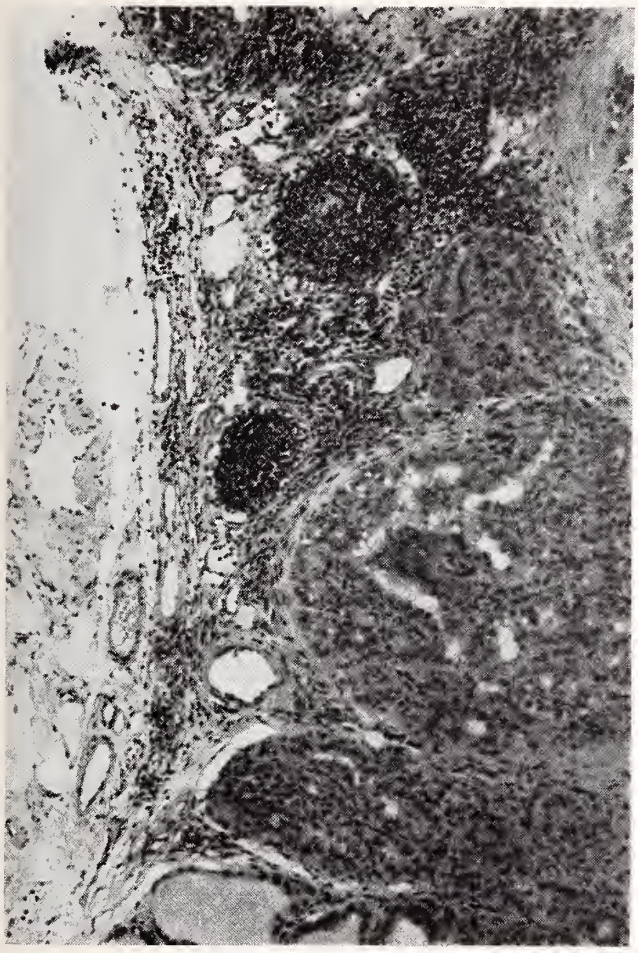


Figure 7. Lymph node replaced by thyroid carcinoma except for small lymphoid remnants at periphery. H&E ×100.

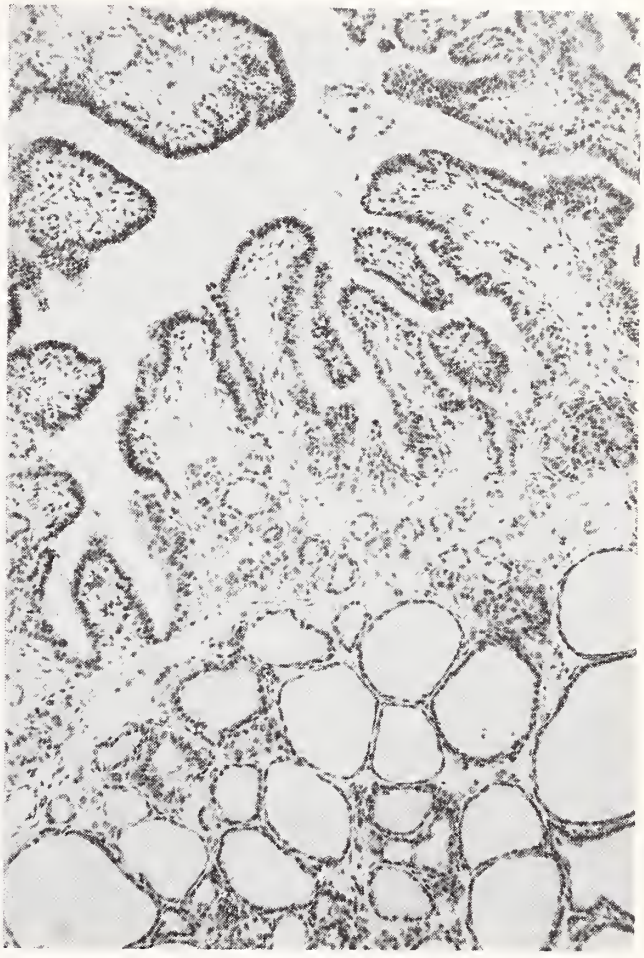


Figure 8. Lymph node. Well-differentiated papillary and follicular (colloid) carcinoma replacing lymphoid elements. H&E ×125.

she had received an unknown amount of x-rays to the upper chest and neck during diagnostic studies for possible congenital heart disease. Four years after subtotal thyroidectomy she showed no signs of recurrent carcinoma.[3]

Of the thyroid carcinomas reported in adults following I^{131}, one was later diagnosed in a nodule palpable when the I^{131} was given.[4] In another case, far-advanced carcinoma was recognized six months after treatment with I^{131}. It also was thought to be a coincidental association of neoplasm and therapy.[5] In a third instance malignant disease of the thyroid was diagnosed in a 70-year-old woman six years after I^{131} therapy for a toxic nodular goiter. Although the clinical data strongly suggested thyroid carcinoma, histologic confirmation was lacking, and there was evidence that the carcinoma already existed at the time of I^{131} therapy.[6]

Burke *et al.*[7] have recently reported the coexistence of thyroid carcinoma and recurrent hyperthyroidism in a 37-year-old woman 10 years after I^{131} treatment for Graves' disease. This may be accepted as the first reported instance in an adult of thyroid carcinoma with its clinical onset at a sufficient interval after I^{131} therapy to dispel doubts as to the temporal sequence, but Burke cautions against the unwarranted assumption of a cause-effect relationship.

Our case resembles Burke's as to the age and sex of the patient, as to initial symptoms and treatment, and as to the time of observance of the carcinoma. The two cases are similar also in that neither showed clinical evidence of profound depression of thyroid function after I^{131} therapy. Burke's patient was lost to follow-up care, but apparently had no indication of thyroid dysfunction until hyperthyroidism recurred 10 years after I^{131} therapy. Our patient remained clinically euthyroid, and only the presence of a palpable thyroid nodule led to the recognition of thyroid carcinoma. In both cases, carcinoma was associated with focal hyperplasia.

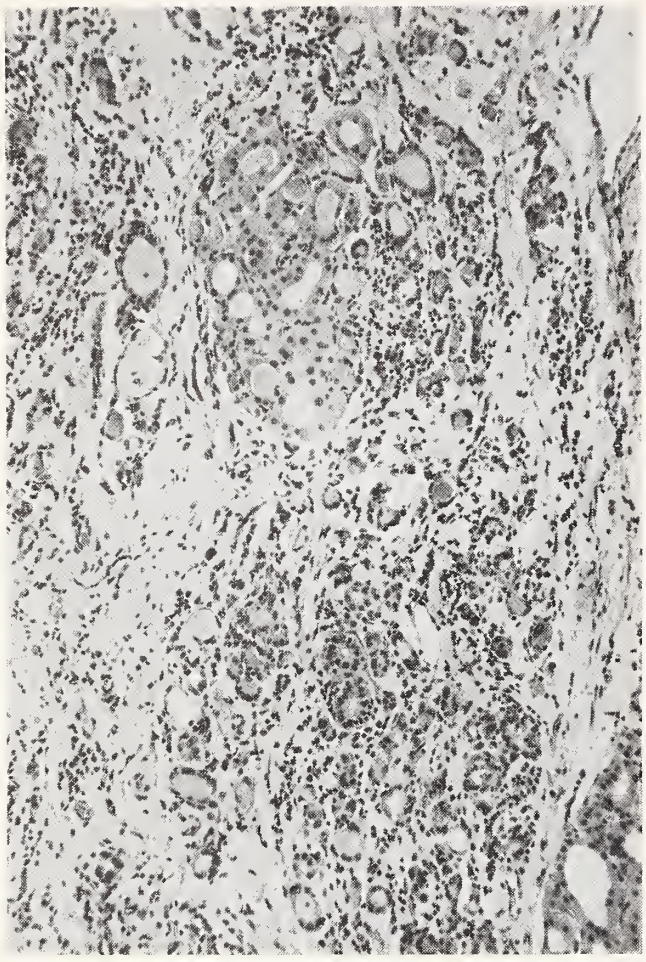


Figure 9. Diffuse atrophy and fibrosis with mild lymphocytic infiltrate, in patient J. N. Moderate cellular dysplasia is evident. H&E ×150.

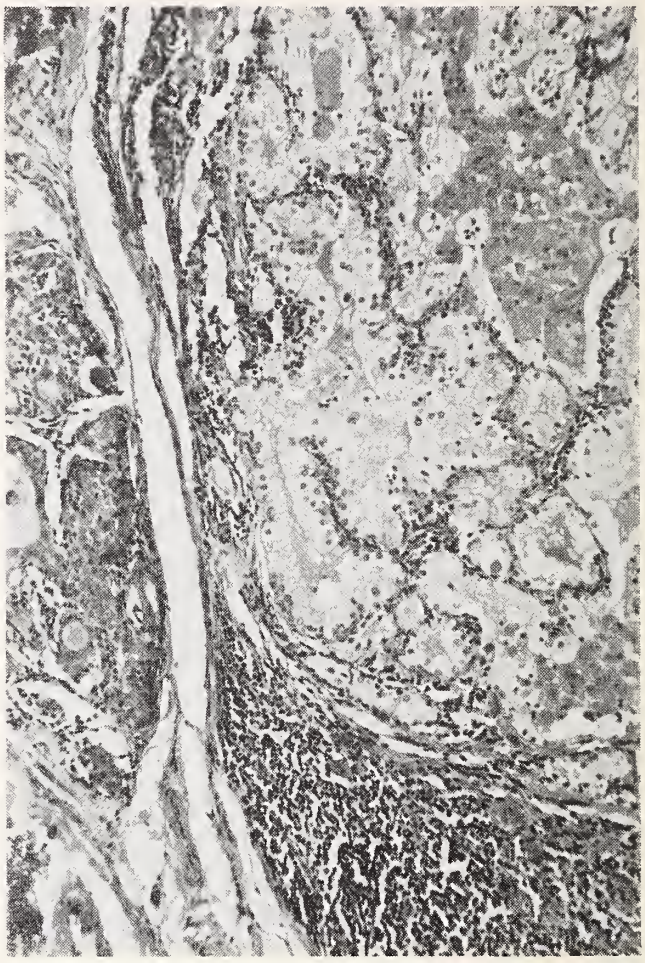


Figure 10. Atypical nodule composed of large oxyphilic or pale vacuolated cells in patient J. N. Focal lymphocytic infiltrate at periphery of nodule. H&E ×150.

In contrast to Burke's experience, we found none of the chronic post-radiation changes described by Vickery.[1] Multiple thyroid nodules of a distinctive type have been described in association with these irradiation effects.[2] We have seen such an example recently, combining the features of atrophy, fibrosis, lymphocytic infiltration and cellular dysplasia, with atypical nodules of oxyphilic or vacuolated cells (Figures 9 and 10). This second patient, J.N., was a 32-year-old woman who had been treated 11 years earlier for hyperthyroidism by the administration of 2.3 mc. of I^{131}, followed by a 24-hour uptake of 65 per cent. Subsequently she had taken desiccated thyroid U.S.P., 120 to 240 mg. daily, for nine years, before the appearance of a thyroid nodule in the summer of 1967. Little change was noted during the eight months between then and her thyroidectomy, in February, 1968. Just before operation her total serum thyroxine was 4.2 mcg. per cent, and her thyroidal uptake of I^{131} was 9 per cent in four hours and 18 per cent in 24 hours. The nodule did not take up the isotope in the scintiscan. The apparently benign nature of her nodular thyroid growth was in accord with the cases reported by Sheline *et al.*[2]

A critical appraisal of the available data raises the question of whether radioiodine therapy in an adult may inhibit rather than promote thyroid carcinogenesis. The very few cases of malignancy reported following such therapy do not exceed the number to be expected on a chance basis. Actually the rate is much lower than the 2.5 per cent incidence of carcinoma recently reported in hyperthyroid patients.[8]

Of the two cases best documented as having had the onset of carcinoma after radioiodine therapy—Burke's case and ours—both exhibited post-radiation thyroid function at or above normal levels. Neither patient received suppressive doses of thyroid hormones after I^{131}. In citing the advantages of radioiodine therapy

for Graves' disease, Crile[9] stresses the importance of adequate dosage. He states: "Irradiation in doses so small that the reproductive power of the thyroid cell is not inhibited predisposes to cancer, as in the cases of small doses of irradiation given to an infant for an enlarged thymus." The small number of cases currently on record supports this view for benign as well as malignant lesions. Sheline *et al.*[2] found euthyroid function in each of eight children and adults who developed nodules a long time after I^{131} therapy. Our patient, J.N., is unique in that multiple atypical nodules developed in spite of the administration of thyroid U.S.P., in amounts presumably adequate to suppress thyrotropin production. It therefore is possible that radiation-altered cells susceptible to low levels of hormonal stimulus may in rare instances persist even in glands profoundly affected by irradiation.

The recorded evidence strongly supports the view held by Crile[9] and by Dunn and Chapman[10] that I^{131} provides a relatively safe treatment of hyperthyroidism. The appearance of tumors in thyroid glands long after radioiodine therapy is a rare occurrence, and almost always is associated with normal or high levels of function. When nodules do appear, the possibility of malignancy demands adequate surgical therapy.

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Oculoglandular Tularemia: A Case Report

RODNEY A. ANDERSON, M.D.
Iowa City

TULAREMIA IS A DISEASE transmitted by animals to man, and is caused by a gram-negative organism, Pasteurella tularensis. It is harbored by several wild animals including rabbits, ground squirrels and other small rodents. There have been epidemics among domestic animals such as dogs and sheep.[1] The disease is transmitted between animals by blood-sucking insects. It usually is transmitted to man by direct contact with infected animals, although epidemics caused by contaminated water supplies have been reported.[2] Transmission from one human being to another is unknown.

Several types of infection have been described. Typhoidal and pulmonary types are generally seen among laboratory workers who have come in contact with infected laboratory animals. The ulceroglandular type of infection is the best known. In this type the organism produces an ulcer in the skin or mucous membranes, and that lesion is followed by lymphatic involvement and a severe systemic disease which can be fatal but usually responds to adequate treatment.[3]

A variant of ulceroglandular tularemia is the oculoglandular type, in which the organism is transferred to the eye, produces conjunctival ulcers and nodules, and then invades the lymphatic system and produces the systemic disease.[4] Following is a description of a case of oculoglandular tularemia.

CASE DESCRIPTION

A 30-year-old laundry-route salesman reported to the Ophthalmology Department at the

Dr. Anderson is a resident in ophthalmology at the U. of I. College of Medicine.



Figure 1. Patient's face before treatment was started. Note the inflammation of the left eye and the facial swelling.

University Hospitals after he had had a red, irritated left eye for 24 hours. There was no history of injury, and there had been no previous episodes of eye difficulty. The patient did have diabetes mellitus, but he felt it had been under control. When first seen, he did not appear ill. His visual acuity was 20/20 in both eyes. Examination of the eyes revealed slight edema of the left upper and lower lids. Marked injection and chemosis of the palpebral conjunctiva were present, and there was a purulent exudate. There were no papillae or follicles. There was slight episcleral injection. A pre-auricular lymph node was palpated on the left. Examination of the cornea revealed no abnormalities, and the anterior chamber was clear. External examination of the right eye was normal. Pupillary reactions were normal. Examination of the fundi revealed a few drusen in both macular areas, but no evidence of diabetic retinopathy. There was felt to be a purulent conjunctivitis in the left eye, and a bacterial culture was taken. Treatment was started with triple antibiotic drops to the left eye, and



Figure 2. Left eye, showing the shallow ulcers of the lower palpebral conjunctiva.

the patient was instructed to return two days later for a follow-up examination.

On his return, he was obviously very ill. His temperature was 103°F., and he was suffering intense malaise. Examination of the left eye revealed a more intense conjunctivitis, and there were several small, shallow ulcers in the palpebral conjunctiva of the lower lid, and several yellow nodules in the palpebral conjunctiva of the upper lid. The cornea and anterior chamber had remained clear, and the remainder of the eye examination was normal. The right eye had remained normal.

The general examination revealed a marked tender swelling in the parotid region on the left. The patient had a herpes simplex lesion on his lower lip, at the left, but otherwise his general physical examination was within normal limits.

The additional history that the patient gave was interesting, in that four days prior to his initial visit to the Eye Clinic he had gone hunting, had killed four rabbits and had cleaned them. He thought one rabbit might have been diseased, for he had seen white spots on the muscles, and on opening the thoraco-abdominal cavity had discovered white spots on the liver. He discarded that rabbit in the garbage.

The culture that had been taken two days earlier had grown no organisms, but because of the history and findings compatible with tularemia, the patient was admitted to the hospital for treatment. His admission laboratory examinations showed a urine with a specific gravity of 1.035 with 1 + protein and 4 + glu-

cose. The hemoglobin was 15.6 Gm., and there were 6,300 white blood cells per cubic millimeter, with 15 band forms, 51 segmented neutrophils, 20 lymphocytes and 14 monocytes. A chest x-ray was normal. The fasting blood sugar was 95 mg. per cent.

Agglutination tests for brucella and tularemia were both negative, but a conjunctival swab, gram-stained, revealed organisms which appeared to be Pasteurella tularensis. Consultants from the Infectious Disease and Diabetic Services of the Department of Internal Medicine said that streptomycin was the antibiotic of choice, and the patient was given 1 Gm. of streptomycin for two doses on the first day of treatment, and 0.5 Gm. of streptomycin twice a day for nine days thereafter. His insulin dosage was adjusted to control his diabetes.

The patient remained febrile for about 36 hours after antibiotic treatment was begun. He showed steady improvement on antibiotic therapy, with the conjunctival ulcers healing and the parotid swelling resolving. The small nodules in the left upper lid persisted for a time, but gradually cleared. It should be noted that guinea-pig cultures were positive for tularemia. The patient was discharged from the hospital three days after discontinuation of streptomycin therapy, and was instructed to return for a follow-up examination. He also was referred to the Diabetic Out-clinic for follow-up of his diabetes.

When he came back 10 days later, he appeared well. His ocular examination was normal, and he had no complaints. A blood specimen drawn at that time revealed a tularemia agglutinin titer of 1/320.

DIFFERENTIAL DIAGNOSIS

This particular form of tularemia must be differentiated from other entities which produce severe conjunctivitis with regional lymph node swelling. One of these is Parinaud's oculoglandular syndrome. In 1889 Parinaud described several cases of granular conjunctivitis with preauricular node swelling, fever, malaise and spontaneous recovery after three to four months. He felt that those cases were of animal origin. This entity became known as Parinaud's oculoglandular fever.[5] With modern diagnostic techniques, specific diagnoses can be made in most cases.

Tuberculosis may produce a nodular conjunctival inflammation with a lymph-node involvement which may progress to a true suppuration of the regional lymph nodes. The leptothrix organism can produce a granuloma of the conjunctiva, usually under the upper lid. There may be just a single lesion and a local inflammation of the preauricular nodes, but no systemic illness. In such cases, biopsy is usually necessary to prove the etiology. Cat-scratch disease is another entity which can produce an oculoglandular inflammation and a systemic illness.[4]

Rarer causes of the oculoglandular syndrome are syphilis, lymphogranuloma venereum, and certain fungal, viral and rickettsial diseases. Tularemia can be differentiated from the above conditions by the presence of multiple conjunctival lesions and shallow ulcers as well as nodules, by a severe systemic infection, by the history, and by confirmation with a stained bacterial smear, culture on special media and serum agglutination titers. Although no etiology can be found for some cases of oculoglandular syndrome, most of them fit into one or another of the above categories.

TREATMENT

Several broad-spectrum antibiotics have been found effective in the treatment of tularemia. Tetracyclines and chloramphenicol have been useful. However streptomycin remains the antibiotic of choice, and it should be given in adequate doses for at least eight days. It has been the most effective in producing rapid recovery and preventing relapse.[3]

INCIDENCE

Tularemia is not a rare disease, but it has become less frequent in recent decades. There has been a steady decline in its incidence in the United States. In 1950 over 900 cases were reported nationally, and by 1967 there were just 184 reported cases.[6] In Iowa since 1959, the incidence has been very low, ranging from 0 to 2 cases per year.[7]

The oculoglandular form is rare. A study of 78 cases of tularemia that occurred in Missouri between 1947 and 1951 included only one case of the oculoglandular variety.[8]

SUMMARY

A case of oculoglandular tularemia has been reported. The differential diagnosis, treatment, and incidence in the United States and in Iowa have been discussed.

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Rupture of Left Subclavian Artery and Fatal Hemorrhage in Patient With Multiple Neurofibromatosis

ROBERT M. CARDELLI, M.D., and
WILLIAM F. McCORMICK, M.D.
Iowa City

VASCULAR LESIONS ASSOCIATED with multiple neurofibromatosis (von Recklinghausen's disease) are uncommon,[1] and vascular lesions presenting as emergencies in this disease are rare.[2, 3] To our knowledge this is only the second reported case of fatal hemorrhage due to rupture of a major artery in a patient having von Recklinghausen's disease without any associated connective-tissue disease or vascular malformation (e.g., Ehlers-Danlos syndrome[4]) predisposing the arteries to friability and rupture.

The first case—one in which a 31-year-old normotensive male died of massive hemorrhage from a ruptured left subclavian artery five days after a relatively minor automobile accident—was reported by McCormick.[5] He felt that it represented delayed post-traumatic rupture, for there was a large bruise immediately over the area and there was granulation tissue at the rupture site, showing that the lesion was at least several days old. No vascular disease was found that could account for spontaneous rupture. Specifically, cystic medial necrosis and arteritis were absent.

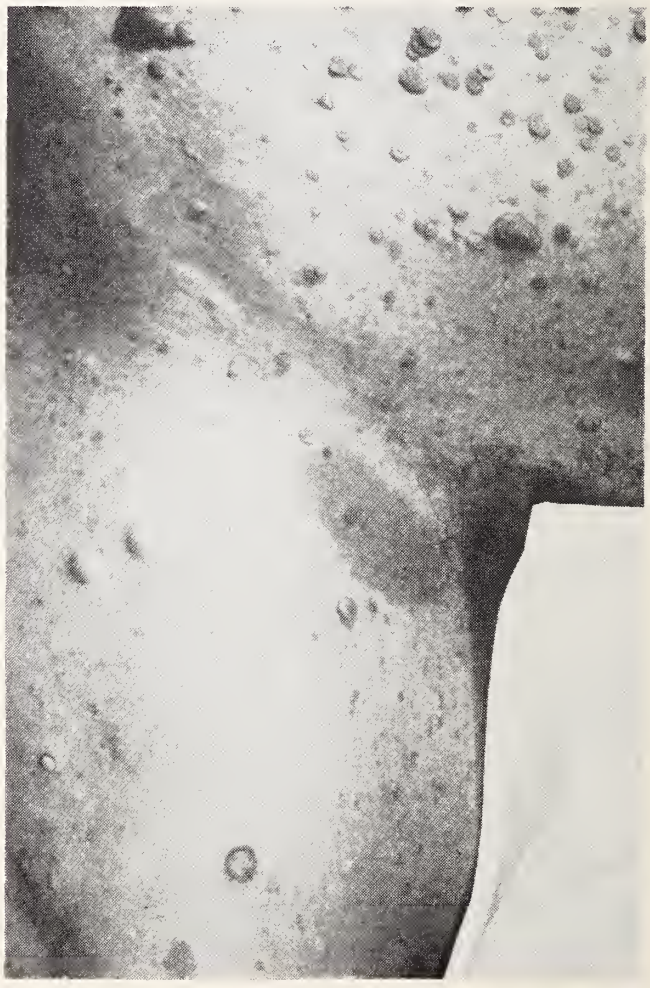


Figure 1. Photograph of right inguinal area demonstrating café au lait spot and multiple cutaneous neurofibromas.

Dr. Cardelli is a resident in pathology, and Dr. McCormick is a professor and chief of the Division of Neuropathology at the U. of I. College of Medicine. Requests for reprints should be addressed to Dr. McCormick.



Figure 2. Photograph of aortic arch and major branches. A transverse, full-thickness tear is seen in the left subclavian artery 2 cm. from its origin (arrow). A small hematoma can be seen in the sheath in this area. There is severe atherosclerosis of the aorta.



Figure 3. Photomicrograph of the left subclavian artery, showing a full-thickness tear and hemorrhage into the adventitia and sheath (hemolysin and eosin stain × 100).

CASE REPORT

Our case involved a 61-year-old housewife with von Recklinghausen's disease (Figure 1). She had a history of mild hypertension (blood pressure 160/90 mm. Hg), but otherwise she was in good health. Two hours before her admission she had experienced a sudden onset of pain in her upper back and left upper chest, associated with swelling in the left neck area. On examination she was found to have a soft, non-pulsatile mass in the left neck and supraclavicular area. No bruits were heard. A chest x-ray and barium swallow were suggestive of a mass in the mid- or posterior-mediastinum. The left neck mass was aspirated with a needle, and venous blood—reportedly clotted—was obtained. Eight hours after admission, the patient suddenly became unresponsive and died.

At necropsy a transverse, full-thickness tear was found in the left subclavian artery 2 cm. from its origin, with blood dissecting into its vascular sheath (Figures 2 and 3). Hemorrhage had dissected into the neck to involve the anterior and posterior tracheal tissue. Blood had ruptured through the left parietal pleura, and 1,900 cc. of fresh blood and clots were obtained from the left thorax. There was severe atherosclerosis of the aorta, but only minimal involvement of the carotid arteries, and none in the immediate vicinity of the tear. No medial degeneration or other vascular abnormalities were found.

COMMENT

Our purpose has been to present another case of fatal hemorrhage in a patient with von Recklinghausen's disease. One previously described patient had had obvious vascular malformations, and another had experienced minor trauma which, in retrospect, seemed possibly to have been coincidental rather than causal. No history of trauma was elicited in our case, and no connective-tissue disease or

malformation was demonstrated. The etiology is not known.

We hope that this report will help increase clinician's awareness of potentially fatal vascular complications in patients with von Recklinghausen's disease.

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Audiovisual Techniques in the Teaching of Anatomy: Television

W. K. METCALF, M.D.,
D. J. MOFFATT, M.B., Ch.B.,
D. A. GRIFFITHS, M.B., Ch.B. and
A. W. JACOBS, M.A.
Iowa City

THE USE OF CLOSED-CIRCUIT television in the teaching of anatomy is by no means new, and it has been discussed several times in print.[1-6] Most applications, however, have been limited to one area of use, and student evaluation of it has not been very complete. We therefore present our experience in using it with a freshman class of 130 medical students.

Television equipment is expensive, and many people in the unfortunate position of having to justify the cost of it and of being anxious to keep it in constant use have felt driven to use it for purposes to which it is not suited. We were more fortunate. Our television equipment was already on hand, having been acquired for a former project, and it was being under-used. Our only criterion for deciding the extent to which we might utilize it was its specific value for the particular purpose we had in mind.

After careful consideration and several months of pilot studies, we decided that television could be employed usefully in the following ways: (1) as the introduction to each day's dissection program; (2) as the basis for a lecture demonstration to an entire class; (3) for presenting patients in motivational clinical lectures and living-anatomy classes; and (4) for review sessions at the end of the study of each anatomic region and prior to the final examination.

Dr. Metcalf is a professor, Dr. Moffatt is an assistant professor, Dr. Griffiths is a visiting assistant professor, and Mr. Jacobs is a graduate fellow in the Department of Anatomy at the U. of I. College of Medicine.

INTRODUCTION TO THE DAY'S DISSECTION

Just prior to each day's work in the gross-anatomy laboratory, a short televised demonstration was shown of the procedure for that day, the difficulties that might be encountered and the structures that should be displayed. It was a live presentation in front of the entire class, and it often was accompanied by related demonstrations, e.g., lung inflation, use of paper laryngeal models, etc. At first the showing took place in a lecture theater, but subsequently it was moved to the gross laboratory. That change brought a greatly increased impact and sense of relevancy, together with a considerable saving in time and an avoidance of loss of continuity.

LECTURE DEMONSTRATIONS

In the lecture situation, television was tried in two contexts: (1) as an adjuvant to illustrate particular points made by the lecturer, where the movement possible under a television camera gave a three-dimensional quality impossible to achieve with a conventionally

projected illustration; and (2) as a guide throughout the presentation—e.g., the demonstration of the muscles and cartilages of the larynx, or the morphology of the skull. In the latter instance each student followed the instructor on an individual skull while an assistant made a simultaneous presentation of the names of various components on an overhead projector. This multiple approach was the only technique by which we could insure the students' prolonged attention in front of the television screen. It is possible that broadcast television may have conditioned them to 12-minute intervals between commercials.

CLINICAL-ANATOMY LECTURES

The objective of lectures in clinical anatomy was not to teach clinical medicine, but to motivate students to learn anatomy. All lectures were given by practicing physicians and their willing cooperation was matched only by the students' enthusiastic interest. The demonstration of particular points on actual patients was especially popular. Television had two functions in some classes: (1) it enabled the lecturer to demonstrate a particular point in the examination to every student in the class simultaneously, and (2) recording the examination on video tape greatly reduced inconvenience and embarrassment for the patients.

LIVING-ANATOMY DEMONSTRATIONS

The living-anatomy classes had two objectives: (1) to provide students an opportunity to correlate the observations they had made on one another with their personal investigations of body structure made in the gross laboratory; and (2) to give each student some experience in handling and examining a living human body other than his own. These purposes are best achieved with very small groups of students under the close supervision of medically qualified instructors. Such a procedure would have been impracticable within the limits of the timetable and of the three faculty members' endurance. Closed-circuit television overcame this difficulty satisfactorily, and was even advantageous in demonstrating some structures—e.g., the opening of the parotid duct and the response of the intrinsic muscle of the hand to electrical stimulation.

VIDEO-TAPE REVIEWS

Short video-tape reviews were prepared, and were presented to the class every two weeks. The presence of the instructor who prepared the tapes and the fact that each tape had been made especially for the particular class were means by which the students were made to feel personally involved. Also, these reviews were subsequently made available to students in a series of voluntary class meetings immediately prior to their final examination. The format was simple, involving merely the preparation of a first-class prosection, and a slow and careful presentation of the structures therein, with the names of all of them pronounced at least twice.

ADVANTAGES AND DISADVANTAGES OF CLOSED-CIRCUIT TELEVISION

The impact of a TV presentation results from the fact that television is a familiar medium of communication, and when presented live it has an intimacy which lends itself to student involvement—one of the first requirements of a learning situation. It seems likely that color TV, with which students are now familiar in their own homes, might be still more advantageous.

The possibility of magnifying small details and displaying them simultaneously to a great many students is obviously advantageous. It is difficult for a teacher to repeat a presentation time and time again, and retain the enthusiasm which is essential for effective instruction. The necessity for such repetitions can be more readily avoided by means of live TV than by the employment of many teachers. The spontaneity and flexibility of live television and the inevitability of the unexpected gives it an edge over filmed material, and even over video-tape presentations. However the rather cumbersome lighting and camera equipment that live presentation in front of a class has always required is somewhat distracting. Video tapes are advantageous in this respect, but much technical paraphernalia has been dispensed with in the latest equipment for "live" presentations.

Besides using the tapes for student reviews, faculty members can review them with their own classes for the purpose of commenting upon and correcting their filmed performances.

That is not the least of the uses of video-tape recording. Even during "live" televisings the instructor can know exactly what each student is seeing by looking in the monitor as he proceeds. The resolution obtainable is surprising, and it is possible to capture detail corresponding to that of black-and-white 16 mm. movies. That has not always been possible with our present equipment, for some of our monitors have not been of top quality and are rather old. Students viewing those particular monitors undoubtedly were at a distinct disadvantage. There also is no reason to doubt that the impact of color in our presentations would be of the same nature as the impact of color in movie productions. Despite the fact that our equipment is somewhat old, we have had no difficulty with maintenance problems. We did have the services of a TV cameraman and a systems operator, but more modern equipment would probably make those technologists superfluous, and further increase the versatility of the medium and the simplicity of its operation.

TECHNICAL PRODUCTION

Many teachers who have tried television have been disappointed with their results. We think the principal reason may have been their assumption that TV production would be easy and needed no pre-planning. The reverse is true. Careful planning, including a precise definition of the objectives of the demonstration, the preparation of a working script, and adequate rehearsals—all these are mandatory. Camera angles, the lighting of the set and the determination of the viewing area must be carefully planned. It is extremely helpful to record the rehearsal on video tape for immediate review. By that means deficiencies become clear, ambiguities become evident and irritating mannerisms are revealed. Correction is usually simple. With experience, preparation and rehearsals take less and less time, but they never can be completely eliminated.

We have found that the optimum length of an uninterrupted television performance is 10 to 15 minutes. Longer presentations are possible, but other audiovisual aids should be used to supplement them. This is particularly true of a well-rehearsed video tape, because the students can be quite certain that no catastrophes or glaring errors have marred the performance, and they will thus have less interest in paying it their close attention. It goes without saying that it is essential to reduce technical equipment, cameras, lights, etc. to a minimum. Zoom lenses which keep in focus throughout the zooming operation are indispensible in maintaining orientation with anatomical material. We used a zoom lens, but it did not hold its focus during zooming, and thus there were many difficulties with orientation.

STUDENT OPINION AND ACCEPTANCE

It is unreasonable to ask an instructor whether his class has found his use of television helpful or not. Usually he must base his reply on his own feelings plus those of any student who has felt strongly enough about the matter to discuss it with the instructor. We wished, nonetheless, to know whether the students felt that they were deriving anything useful from our televised demonstrations. We therefore distributed copies of a questionnaire to the students with whom the above described technics had been used for one semester. Responses were voluntary. The questionnaire dealt with all aspects of the gross-anatomy course, but the portion of it dealing with television was as follows:

STUDENT QUESTIONNAIRE
SECTION III—TELEVISION

Television has been used in: (1) introducing the day's dissection; (2) supplementing "formal" anatomy lectures; (3) reviewing selected topics; and (4) presenting living anatomy procedures. Assess the effectiveness of the use of television in each of these areas according to the following rating scale:

A—highly effective
B—moderately effective
C—effective
D—somewhat ineffective
E—totally ineffective

40. Introduction to dissection
41. "Formal" lecture supplement
42. Review of presentations on video tape
43. Living anatomy

Several methods of improving the use of television in teaching gross anatomy are being considered. Assess these proposals individually according to the following ratings:

A—greatly improve effectiveness
B—moderately improve effectiveness
C—slightly improve effectiveness
D—no change in effectiveness
E—decrease the effectiveness

44. Color television
45. Large screen projection television
46. Replace live demonstrations with prerecorded tapes
47. Improve technical production
48. Improve faculty performance
49. More monitors with improved resolution and contrast

It will readily be seen that we asked two types of questions: (1) whether the present methods were effective in their current usage, and (2) what improvements were required.

In the responses to the first group, it was clear that the students had found the videotape reviews, every other week, to be of considerable assistance. The other three types of televised presentations were also judged effective teaching tools, though to a lesser degree. Very few students considered any of our methods of presentation totally ineffective (Figure 1).

But where should we look for improved effectiveness? The answers, we feel, are reflected in Figure 2. Although better technical and faculty performances can only improve the effectiveness of the medium, the students clear-

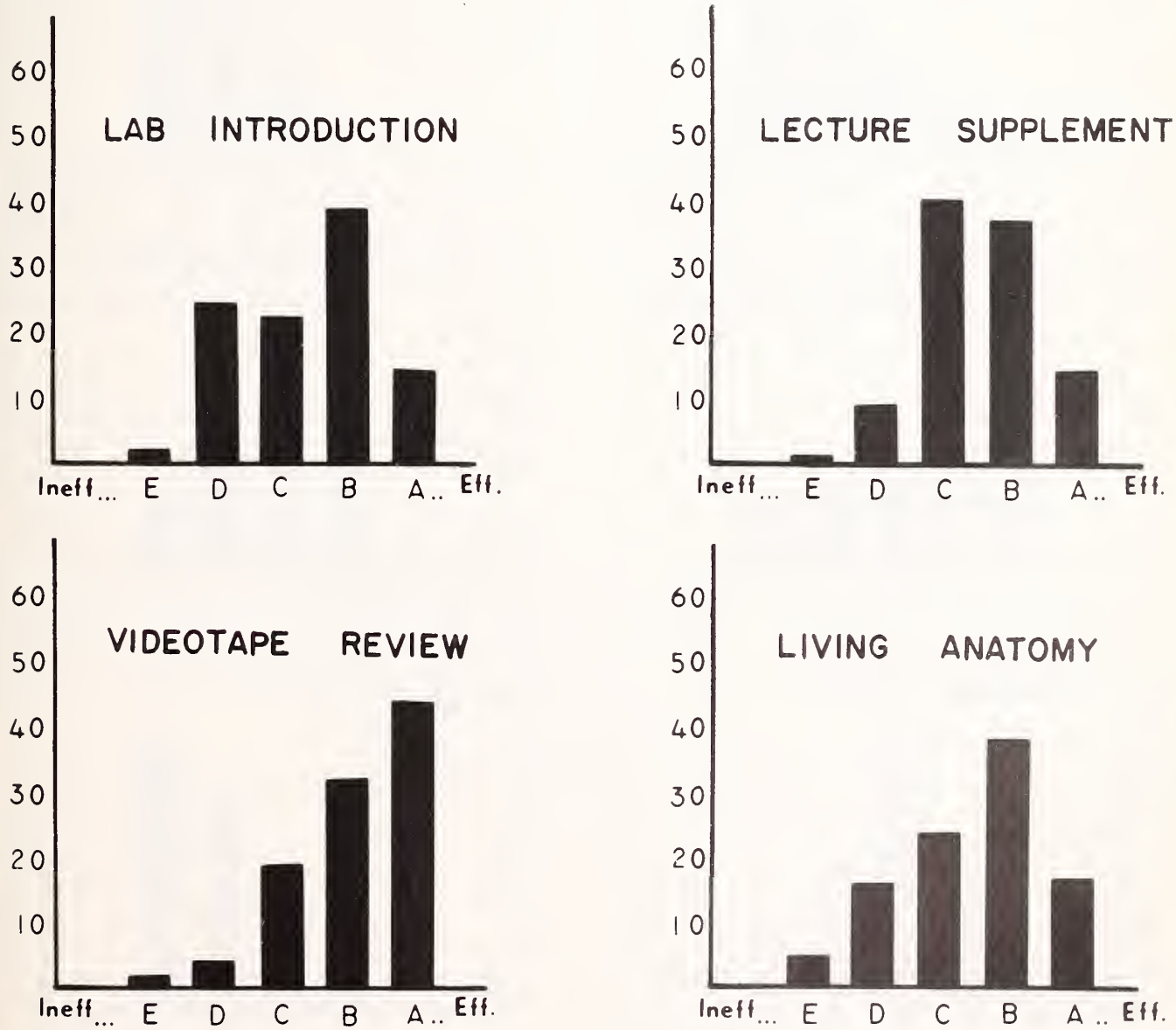


Figure 1. Estimates of effectiveness of televised presentations for the various purposes. The number of U. of I. freshman medical students submitting voluntary and anonymous evaluations was 101.

ly felt that the principal deficiencies lay in the apparatus. From their responses to questions, and to a lesser extent from their individual comments, made at our request at the end of the questionnaire, it was clear that lack of color and difficulties in seeing detail on the rather old monitors had served to detract from the effectiveness of the presentations. A single large-screen projection, whether in black-and-white or in color, would have the additional advantage that one could be certain that all students were seeing the same quality of reproduction, and would avoid the difficulty of keeping a number of monitors in correct adjustment. This would be an even more important consideration in the use of color television.

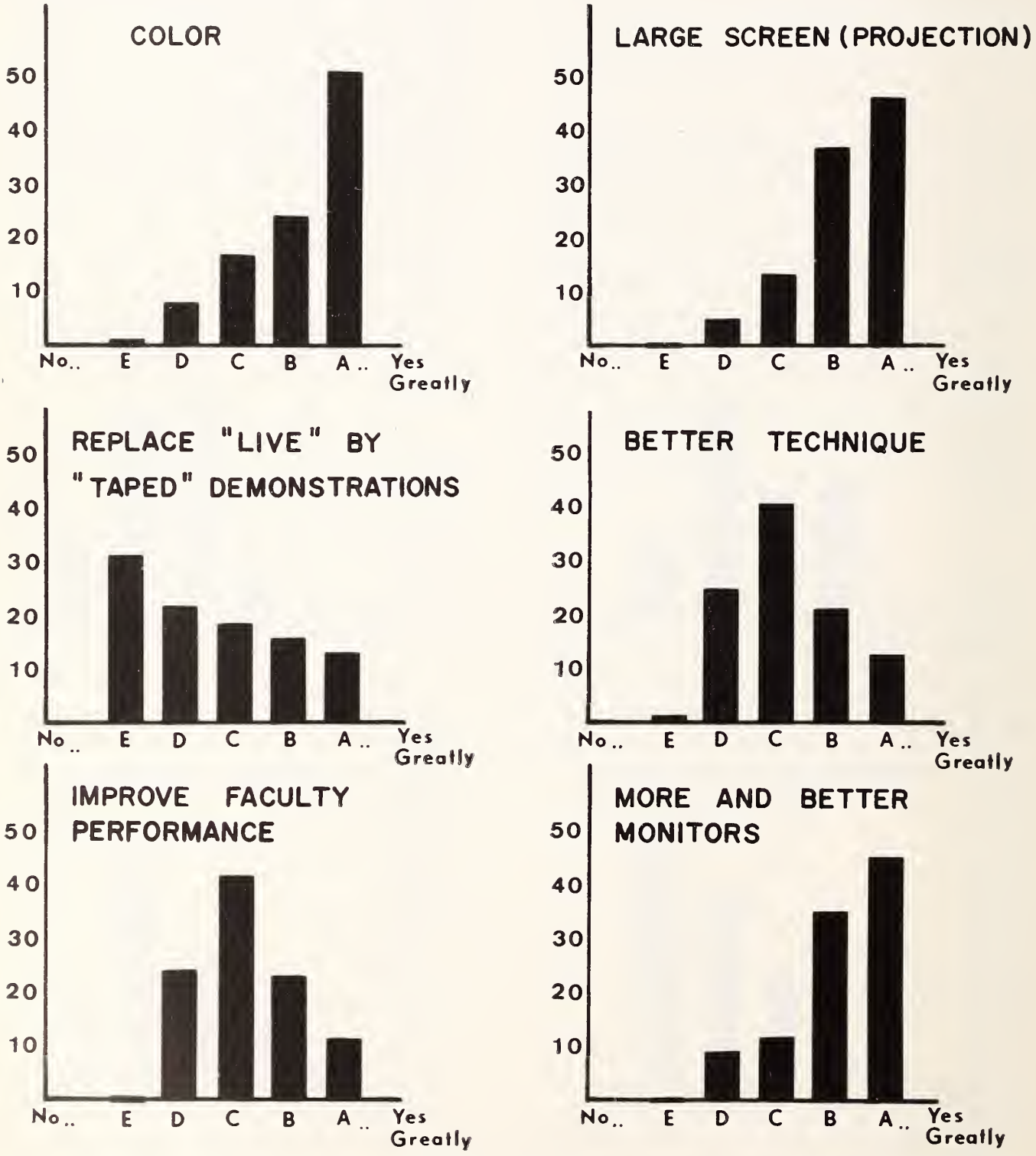


Figure 2. Estimates of the importance of each of several ways in which it was suggested that televised presentations might be improved. Again 101 U. of I. freshman medical students replied voluntarily and anonymously.

SUMMARY

We have used television fairly extensively in a single-semester course in gross anatomy for medical students.

1. Television has been effective in the applications for which we have used it.

2. Both "live" and "prerecorded" demonstrations have roles in this type of teaching program.

3. Technical problems in the use of TV for teaching have been discussed.

4. Of the six ways in which the effectiveness of our presentations might be improved, three appear mandatory. All three amount to a need for improvement in picture quality and clarity. Suggestions for achieving this objective must include the provision of high-quality monitors or of large-screen projection equipment, and above all, of color.

ACKNOWLEDGEMENTS

We wish to express our gratitude to the members of the clinical faculty for their cooperation and participation, to John Tiffany for his technical help and advice, and above all to the freshman medical students for their cheerful support and forbearance.

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AMA Film on Sex Education

"A Look at Sex Education in the School" is a moving picture which all family-life education program planners should see. Originally produced for closed-circuit TV showings during the 1969 AMA Clinical Convention in Denver, it has been made available on 16 mm. film, in color. Prints can be borrowed, free, by medical societies or their Auxiliaries from the AMA Radio and TV Department, 535 North Dearborn Street, Chicago 60610.

The panelists are Orvis A. Harrelson, M.D., director of school health services for the Tacoma, Washington, public schools; Mrs. Paul E. Rauschenbach, Paterson, New Jersey, chairman of the children and youth committee of the Woman's Auxiliary to the AMA; and Wallace Ann Wesley, Hs.D., assistant director of the AMA Department of Health Education. Their discussion is an up-to-date analysis of the issues to be dealt with in implementing the AMA's resolution endorsing family-life and sex-education programs in the nation's schools. Showing time is about half an hour.

Psychiatric and Legal Aspects of Drug Use and Abuse

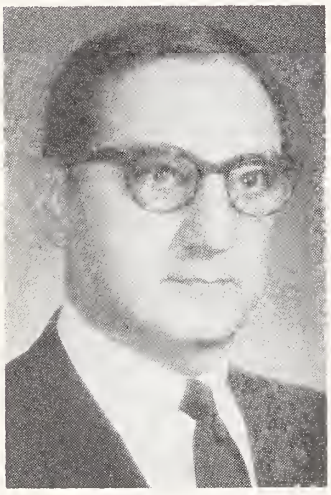
Polarized positions on the use and abuse of drugs are hindering efforts to close the credibility gap between young people and their parents, Dr. Albert S. Norris, a professor of psychiatry at the U. of I., said at a seminar sponsored by the Linn County Mental Health Association, in Cedar Rapids on October 29. "At one end of the spectrum is the Federal Bureau of Narcotics; at the other end is the position recently stated by Dr. Margaret Mead, an internationally famous anthropologist in testimony before a Senate subcommittee," he declared. "By enforcing the 1937 tax act, the Federal Bureau of Narcotics has sought to ban the use of marijuana and other drugs, but has succeeded only in stamping out research on their short- and long-term effects," he continued. "Margaret Mead recommends legalization of marijuana for all persons 16 years old and up. Neither of those polar positions has adequate evidence to support it."

Dr. Norris emphasized the need for research into the effects, both psychological and physical, of marijuana and other drugs before the laws are changed. Since the 1937 tax act became effective, hardly any research has been done on drugs, he asserted. "One research project reported in December, 1968, took one year to get started because of the red tape that had to be cut through before it was approved," he pointed out. "This means that most of the investigators' time was taken up in getting over the hurdles of bureaucracy."

An example of fruitful research is the work done with LSD before the government clamped down, he said. The discovery that LSD might cause genetic damage led to a rapid decline in its use just at the time it had reached a peak of popularity among drug users. That was not because of laws forbidding its use, but because of wide dissemination of the information that it was dangerous.

One of the other noteworthy statements which Dr. Norris made at Cedar Rapids was the following: "Over-reaction to the discovery that a young person has taken drugs can lead to the very thing parents wish to avoid. Such a discovery means that the youth probably has a psychological problem that requires understanding, and a trip to the family physician is far more appropriate than a trip to the local police station."

President's Page



No organization ever had a totally active membership or one fully committed to all its programs or objectives.

These words paraphrase a 1966 comment made by Milford O. Rouse, M.D., then president-elect of the American Medical Association. The occasion for Dr. Rouse's still-true comment was the dedication of the new IMS Headquarters Building.

Dr. Rouse added, "But I would like to see functioning medicine come closer to that goal than anybody else ever has."

How do we do this? How do we maximize interest, understanding and participation? Formidable questions, to be sure.

Society officers must foster a sense of belonging; we need to encourage, receive and give prompt consideration to ideas from the membership; we must demonstrate that progress is being made toward established goals; we need to keep the membership informed; we must provide assurance that responsible supervision is being given the operation of the professional organization in which we share membership.

Broad understanding of the Society's operational blueprint is fundamental. The next several "In the Public Interest" sections (beginning next month) will review the workings of the Society in an effort, hopefully to increase this understanding. This summary is to be provided for the membership as well as for interested lay readers.

Wm M. Kingsley MD

President



Editorials

AN IDEAL PARENT-CHILD RELATIONSHIP

On the day of the splash-down of Apollo 12, November 24, 1969, the DES MOINES REGISTER'S column "What Do You Think?" reported the answers of four fifth-grade youngsters to the question: "Do you look up to the astronauts as heroes?"

A 10-year-old lad replied that to him the astronauts were not really heroes—except perhaps the one who was first to walk on the moon. To him, the boy declared, "My dad is my hero, 'cause he's a really good man and he's really good to me. He takes care of me and works at the new post office. I'd like to be just like him when I grow up!"

Inquiry revealed that the family moved to Iowa 15 years ago from the deep South. The father is a laborer on the Des Moines Post Office construction project, and he has been employed by one general contractor for five years. The boy who expressed such admiration for his father is an adopted child, taken into the home when he was 36 hours old. In all, there are four foster children in the family, of whom he is the eldest. The father and mother are imbued with a desire to help their own people, and in their home there are great love, firm discipline, deep faith, and respect for hard work well done.

Surely the boy's tribute was the finest that any youngster could pay to a parent, and it reflected the spirit of his home. It represents the type of parent-child relationship that is the answer to the problems of delinquency and of deteriorating values and standards in this country today. May the light from their candle spread far!

AVE ATQUE VALE!

With the death of Dr. Ben T. Whitaker, of Boone, on November 5 at the age of 82, the Iowa Medical Society lost an outstanding member and a pillar of strength in the organization for many, many years. A large number of his colleagues lost a close personal friend, and the public lost a dedicated physician.

Dr. Whitaker was elected to the IMS Board of Trustees in 1949; he became its chairman in 1950; and he served as IMS president in 1952-1953. He was also a member of the Board of Directors of Iowa Medical Service (Blue Shield) for many years. In 1959 he was recipient of the IMS Merit Award. Somewhat more recently, the Interstate Postgraduate Assembly honored him by establishing its annual Ben T. Whitaker Award for outstanding medical teaching in Iowa.

Dr. Whitaker was a reserved man who worked quietly and unobtrusively, but in a most effective manner. He and Dr. George H. Scanlon, who died in January, 1969, were staunch friends who guided the Society through many vicissitudes during a period of many years.

"Do not grieve
Because a man died. Men die.
It is the way of life and must be borne.
Rather rejoice because a great and
good man lived."

Editorials continued...

SEX AND THE SINGLE STUDENT

One of the state medical journals recently reported the results of a 1967 student health survey at an outstanding liberal arts college in the Midwest (not in Iowa). If accurate, it reflects changing mores and indicates a rejection of some of the ideals and standards which have guided the older generations throughout their lives.

According to the survey, which was conducted by undergraduate students, almost 40 per cent of the unmarried coeds reported that they had had sexual experience. One out of 13 of these young women said she had become pregnant. More than half of them reported that they had used no method of birth control, and those who had employed birth control measures had used the less effective methods which do not require a physician's prescription.

The results of the survey also indicated that over 20 per cent of the incoming freshman girls and between 36 and 46 per cent of upper-class coeds used the pill regularly. In addition, 1.5 per cent of freshmen and somewhat over 8 per cent of the seniors (unmarried) used diaphragms regularly.

Among the coeds with sexual experience, 187 (39 per cent) had obtained contraceptive devices on physicians' prescriptions. However almost 60 per cent of them had consulted physicians other than their family doctors, a member of the health service staff at the college, or even a practitioner in the community where the college is located. This suggested that they had consulted physicians in strange communities, and that they had no regular medical care or counsel concerning sex or contraception. The survey disclosed that half of the girls with coital experience purchased non-prescription items for contraception from drug stores, and that 10 per cent procured them from parents or friends.

A majority of the young women attending the college were from relatively affluent homes. Sixty-three per cent of the freshmen estimated that their families' annual incomes were between $10,000 and $25,000. They were intelligent young women with excellent academic records, or they would not have been admitted to the college. In addition, colleges usually require character references, and it can be assumed that they had been considered wholesome youngsters in their respective communities and secondary schools. The conclusion drawn from the survey was that the coeds—an intelligent, socially and economically privileged group—had failed to receive adequate sex education, and that they were poorly informed concerning modern contraceptive methods. It also seemed apparent that they had no doctor-patient relationships with physicians whom they could consult concerning sex or contraceptive methods.

That survey was made outside Iowa, but there is no doubt that we have a comparable problem here. As this is written, an organization called "The Ad Hoc Committee for Contraceptives Through Student Health" on the U. of I. campus, in Iowa City, has announced its intention to conduct a march on December 10, 1969, to publicize its demand for a more liberal university policy toward providing women students with birth-control information and contraceptives, presumably regardless of the applicants' marital status.

At Stanford University, in Palo Alto, California, the head of the student health service has recommended that his staff be authorized to prescribe birth-control pills for unmarried students.

Under the circumstances, it appears that our colleges and universities are likely, in the near future, to begin providing gynecologic and psychologic counseling to the young women on their campuses. Perhaps indeed, guidance in interpersonal relationships and sex and morals needs greater emphasis than matters academic.

It appears that a compulsory high school course designed to prepare young people for the responsibilities of marriage would be a very constructive venture. In this era more young

women are married at 18 than at any other age, and teenage marriages have increased 500 per cent since 1940. Unfortunately, a considerable number of girls are pregnant at the time of their marriage. It is recognized that the divorce rate for teenage marriages is three times as high as it is for married persons in the 21 to 25 year age group, and this difference is attributed to the fact that most teenagers are psychologically, socially and educationally unprepared for marriage or parenthood. It is estimated that of one million abortions performed in this country each year, 180,000 are performed on high school students. Recent disturbing increases in venereal disease incidences in this country have occurred mostly among teenagers.

Sex education must not be restricted to a limited set of anatomic and biologic facts, but rather must be a lifelong acquisition of knowledge about what it is to be a man or a woman. Its purpose is much broader than its title implies. Proper sex education should be looked upon as character training to make the individual knowledgeable and emotionally healthy, and to instill values and standards that will help make him or her a responsible adult, able to choose a mate with whom a stable and happy marriage can be created and can be maintained.

Ideally, sex education should take place in the home, but it is well recognized that it is only in the unusual home that it actually is accomplished. Thus there is a need for sex education in the schools. Surely young people should not be denied teaching which will help them become wholesome young adults, possessing the character and the self-discipline that they need if they are to achieve happiness for themselves and to provide it to their children.

LET'S NOT BE SENTIMENTAL ABOUT ALCOHOLICS

In a recent symposium on the subject of alcoholism, held at the Trouro Infirmary, in New Orleans, and published in the September, 1969, issue of the JOURNAL OF THE LOUISIANA STATE MEDICAL SOCIETY, Dr. Mayo L. Emory, of New Orleans, expressed emphatic opposition to the generally accepted idea that alcoholism should be thought of and referred to as a disease.*

He declared that by calling alcoholism a disease we rob the alcoholic of the one prop that he needs most desperately—the stimulus to accept responsibility for his own acts. He said it would be quite comparable to call poverty a disease!

Dr. Emery admonishes physicians not to become discouraged by failures or breakdowns in their management of alcoholics. But he urges doctors not to embark upon rescue missions, or to commit themselves to curing such patients. To a physician who is inclined to adopt such an attitude, he says, the alcoholic "will let you try, and try, and try, and try and try, and will defeat you." Rather, he says, "you can commit yourself—even dedicate yourself—to helping the patient help himself, to gird up and to encourage him to be critical of his failures without criticizing, and to express a belief that the patient can and indeed may succeed in ordering his life better."

Rather than a disease, Dr. Emory believes that alcoholism is a behavioral aberration with an addiction overlay. It begins in a social setting as the "in thing to do," it becomes a part of the social habit of the person and the group, and it progresses into addiction.

He states emphatically that the alcoholic is indeed sick. This cannot be denied. And he becomes sick as he is poisoned by alcohol. The management of the acute alcoholic during the first four days to a week is crisis treatment, and situations must be met as they arise. The patient should be in a hospital or a detoxification center where vital functions can be maintained and where indicated therapy can be administered.

When the patient begins to function more normally, Dr. Emory says the treatment "depends upon the drive, interest and impact of the physician. He must provide sufficient discipline, direction and motivation to propel the patient through the treatment program." To initiate such a program of training and reconditioning requires a minimum of three weeks.

* Emory, M. L.: Medical management of effects of alcohol and alcoholism. J. LOUISIANA M. SOC., **121**:279-283, (Sept.) 1969.

Editorials continued...

The need for the physician's making a continuing effort to help the alcoholic help himself is obvious.

Dr. Emory classifies alcoholics as follows:

1. Those people who drink because it is the "in thing to do." They are usually young people who do not yet know who they are, and they are seeking identity. They are sheep; they follow the crowd.

2. Those people who are disturbed and maladjusted, and who use alcohol to allay their fears and to relate to others. These are lost souls who do not know how to order their lives.

3. Those people for whom alcohol provides a mask of santity, a desperate crutch which allows them to function in society. These are desperate people.

4. Those who are compulsive drinkers—doers or users of anything. The true nature of such people is poorly understood.

He concludes with the statement: "As a physician and a citizen let me say that there is no treatment for alcohol or alcoholism until we hold the alcoholic responsible for his act and make it clear that drunken behavior has no place in our society."

The concept that alcoholism is *not* a disease certainly will not be universally accepted. However it is provocative, and it will do us some good to think about it. Alcoholism is a serious problem, and it deserves serious thought and concerted effort.

CONTROL OF BLEEDING IN HEMOPHILIC PATIENTS

A recent news release from the HEW Department reports that a high-potency, highly purified concentrate of antihemolytic factor (AHF) for the prevention and control of bleeding in victims of hemophilia has been developed by the American Red Cross. It is the outcome of a research program of the National Heart Institute.

According to the report the new concentrate contains 40 to 100 times as much antihemolytic factor as an equal volume of whole blood or plasma. It would appear to offer a major advance in the management of classical hemophilia, the commonest of the hereditary bleeding disorders, said to afflict 100,000 Americans.

The concentrate is prepared from blood plasma by precipitation with polyethylene glycol. The technique is said to be relatively simple, and can be used to extract the factor from large volumes of plasma. AHF is chemically stable and can be stored at refrigerator temperature for prolonged periods without loss of potency. Because of its high purity there is little risk of side reactions. After extraction of the AHF, the plasma can be processed to yield albumin, gammaglobulin and other protein fractions. Thus the cost of preparing the product is reduced.

According to the release, the concentrate will be manufactured for the Red Cross, and a license for that purpose has recently been issued by the Division of Biologic Standards, National Institutes of Health. It will be some time before the concentrate is available in quantity; however the new technique will make quantity production feasible, and help resolve many of the serious problems of patients with hemophilia. This will be welcome news to physicians who are called upon to manage patients afflicted with this serious inherited disorder.


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Education and Research Foundation
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AMA-ERF

COMING MEETINGS

IN STATE

Feb. 10-13 **Refresher Course for General Practitioners,** University of Iowa College of Medicine, Iowa City.

CONTINENTAL U. S.

Jan. 2-4 **Medicine and Law sponsored by American College of Physicians, University of Southern California Institute of Psychiatry and Law,** Los Angeles.

Jan. 2-6 **Postgraduate Course on Function and Dysfunction of Gastrointestinal Tract sponsored by American College of Physicians,** Americana Hotel, Bal Harbour, Florida.

Jan. 11-14 **Society of Thoracic Surgeons,** Regency Hyatt House, Atlanta.

Jan. 14-15 **Postgraduate Course on Selected Problems in General Surgery and Vascular Surgery,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.

Jan. 16-17 **American Society for Surgery of the Hand,** Annual Meeting, Palmer House, Chicago.

Jan. 17-22 **American Academy of Orthopedic Surgeons,** Palmer House, Chicago.

Jan. 18-24 **Sixteenth Annual General Practice Review sponsored by University of Colorado School of Medicine,** Denver.

Jan. 22-23 **Postgraduate Course on Computers in Medical Practice sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Jan. 23-24 **Arizona Chapter, American College of Surgeons and Arizona Society of Anesthesiologists, Joint Meeting,** Arizona Inn, Tucson.

Jan. 26-28 **International Medical Assembly of Southwest Texas,** Hilton Palacio Del Rio, San Antonio.

Jan. 26-29 **Practical Approach to Selected Clinical Problems sponsored by American College of Physicians,** Ochsner Medical Foundation, New Orleans.

Jan. 29-30 **Second Annual Symposium on Chronic Respiratory Diseases sponsored by University of Nebraska Medical Center,** Omaha Campus, Omaha.

Jan. 30-Feb. 1 **Southern Radiological Conference (14th),** Grand Hotel, Point Clear, Alabama.

Feb. 2-4 **Sectional Meeting of American College of Surgeons,** Portland Hotel, Portland, Oregon.

Feb. 2-6 **Postgraduate Course on High Risk Infant Care (Limited) sponsored by University of Colorado School of Medicine,** Denver.

Feb. 4-5 **Postgraduate Course on General Practice,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.

Feb. 8-9 **Annual Congress on Medical Education,** Palmer House, Chicago.

Feb. 8-10 **American Society for Aesthetic Plastic Surgery,** Marriott Motor Hotel, Atlanta.

Feb. 9-10 **Postgraduate Course on Cardiac Auscultation,** Kansas University Medical Center, Kansas City, Kansas.

Feb. 9-11 **Postgraduate Course on Cardiopulmonary Resuscitation (for doctors, nurses and dentists) sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Feb. 12-14 **Southwestern Medical Association,** Sheraton Motor Inn, El Paso.

Feb. 12-14 **Second National Conference and Exposition on Electronics in Medicine,** Fairmont Hotel, San Francisco.

Feb. 14-15 **26th Annual Meeting, American Academy of Allergy,** Jung Hotel, New Orleans.

Feb. 16 **Workshop on Diabetes Detection sponsored by Disease Detection Information Bureau of Chicago,** Sheraton-Dallas Hotel, Dallas.

Feb. 16-18 **Sectional Meeting of American College of Surgeons,** St. Paul Hilton, St. Paul.

Feb. 17-20 **Postgraduate Course of Surgery of the Hand sponsored by University of Colorado School of Medicine,** Humphreys Postgraduate Center, Denver.

Feb. 18 **Postgraduate Course in Office Pediatrics,** University of Nebraska Medical Center, Omaha.

Feb. 18-20 **Frontiers of Medicine 1970 sponsored by Lakeland Graduate Medical Assembly,** Lakeland, Florida.

Feb. 19-20 **Postgraduate Course in Clinical Otorhinolaryngology,** University of Nebraska Medical Center, Omaha.

Feb. 20-22 **Symposium on Rheumatic Diseases sponsored by New Mexico Chapter Arthritis Foundation,** Kachina Lodge, Taos, New Mexico.

Feb. 23-27 **Gastroenterology for Clinical Teachers sponsored by American College of Physicians,** University of Michigan Medical Center, Ann Arbor.

Feb. 25-26 **Postgraduate Course on Selected Topics in Basic and Clinical Immunology,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.

Feb. 25-Mar. 1 **19th Annual Scientific Session of American College of Cardiology,** Rivergate Center, New Orleans.

ABROAD

Feb. 1-14 **International Congress on Alcoholism and Drug Dependence (29th),** Sydney, Australia.

Feb. 14-19 **Symposium of Sports Medicine with International Participation,** Vysoke Tatry, Czechoslovakia.

Mar. 8-14 **International Congress of Ophthalmology (21st),** Mexico City.

Mar. 13-20 **Paediatric Surgical Meeting,** Melbourne.

Mar. 17-20 **Canadian Association of Radiologists, 33rd Annual Meeting,** Montreal.

Mar. 19-21 **Association of Clinical Pathologists,** Edinburgh.

Mar. 30-Apr. 4 **Latin-American Congress of Obstetrics and Gynecology (6th),** San Jose, Costa Rica.

AMA Issues Its Eighth Booklet on Athletic Training Tips

TIPS ON ATHLETIC TRAINING VIII, for high school and college coaches and team physicians, has been published by the AMA Committee on the Medical Aspects of Sports. It is a 26-page handbook covering health examinations for students who wish to participate in athletics; physical readiness for football; hot-weather hints; herpes simplex among wrestlers; the athlete and VD; androgenic-anabolic steroids and sports; the knee in sports; safety in track and field; and a first-aid chart for athletic injuries.

The price of the booklet is 15¢, and it can be bought from the AMA Order Department, 535 North Dearborn Street, Chicago 60610.

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THE JOURNAL *Book Shelf*



BOOK REVIEWS

ATLAS OF OBSTETRIC TECHNIC, SECOND EDITION, by *J. Robert Willson,* M.D., M.S. (St. Louis, C. V. Mosby Company, 1969. $19.75).

This atlas is beautifully done, with drawings depicting, step by step, normal labor as well as the various operative means of delivery. The drawings are superlative and have almost a photographic quality.

Combined with the drawings, the author gives clear cut, concise descriptions of the illustrated procedures.

In this second edition, the section concerning the use of oxytocin for the induction of labor and for stimulation of dysfunctional labor has been rewritten, as well as the section on management of the third stage of labor. New methods of placental localization are also described.

The portion devoted to obstetric analgesia and anesthesia is particularly well done, especially the section on conduction anesthesia.

The material illustrating the technique of cesarean section under local anesthesia, I am certain, will be viewed by older obstetricians with nostalgia.

This text will be extremely useful to the obstetric resident in training as well as to the intern and medical student. It is so well done that I also feel it will be useful in the teaching of student nurses, and should be in the library of every medical school and school of nursing.—*C. W. Seibert,* M.D.

TEXTBOOK OF PEDIATRICS, NINTH EDITION, ed. by *Waldo E. Nelson,* M.D., *Victor C. Vaughan, III,* M.D., and *R. James McKay,* M.D. (Philadelphia, W. B. Saunders Company, 1969. $23.75).

This single-volume textbook of pediatrics is so well known the world over that extensive review is unnecessary. Sufficient to say that it is probably the leading pediatric textbook published. The first single volume edition was published in 1933, and this is the ninth which amply attests the effort exerted by the editors to keep the published information as current as possible.

The three previous editions ('54, '59, '64) were edited by Dr. Nelson alone with the assistance of many collaborators, but for this edition Dr. Nelson has invited Dr. Victor Vaughn, III, professor and chairman of the Department of Pediatrics at St. Christopher's Hospital for Children of Temple University Medical School, and Dr. James McKay, professor and chairman of the Department of Pediatrics at the University of Vermont College of Medicine, to be co-authors with him and assist in the ever increasingly complex task of collecting, sorting and publishing the vast amount of current pediatric knowledge.

In addition to the editors, 77 collaborators have made contributions to the book. As one checks the names in the published list of collaborators he realizes that they have been selected for their specialized knowledge in some particular field of pediatrics.

Illustrations are plentiful and helpful, and following each section is a generous list of references. There are numerous tables and lists of classifications of disease states which add materially to the usefulness of the book. It is a large volume—the total pages numbering 1,589.

This ninth edition of the Nelson, Vaughn, McKay single-volume pediatric textbook can be highly recommended to medical students, house staffs of pediatric departments, pediatricians, general practitioners and all others whose work embraces the health problems of children.—*Lee Forrest Hill,* M.D.

RENAL DISEASE IN CHILDHOOD, by *John A. James,* M.B. (Edin.), M.R.C.P., D.C.H. (St. Louis, C. V. Mosby Company, 1968. $18.50).

This is an excellent book and the author, Dr. James, is widely known for his expertise in pediatric renal disease.

Knowledge concerning renal disease in childhood has accumulated rapidly in recent years. It is, therefore, most helpful to the physician to have an authoritative reference source that goes beyond the information supplied by the general pediatric textbook.

This book, as the author states in the preface, is clinically oriented and emphasizes "diagnosis and treatment, rather than etiology, pathology and pathogenesis." Thus, it is intended for medical students, house staffs of hospitals, pediatricians, generalists and urologists, rather than for the nephrologist. A generous list of references is given at the end of each chapter for the convenience of those who wish more information on particular problems.

The contents of the book, numbering 371 pages (including index) are presented under 15 chapter headings with 104 illustrations. The opening chapter reviews normal anatomy and physiology, and subsequent early chapters discuss symptoms and signs of renal disease, the diagnostic procedures and tests including radiography, the embryology and the congenital anomalies of the urinary tract.

Undoubtedly of greatest usefulness to the practicing physician will be the chapters on urinary-tract in-

fections, acute and chronic glomerulonephritis, the nephrotic syndrome, and acute and chronic renal failure. The diagnostic and therapeutic aspects of these problems are presented in a concise, "straight to the point" manner which provides the physician with excellent guidelines for the management of his patients.

The final chapter concerns dialysis and homotransplantation.

As was stated at the beginning, this book deserves a high ranking, and it is recommended to pediatricians and all others concerned with renal disease in childhood.—*Lee Forrest Hill,* M.D.

GENETICS AND COUNSELING IN MEDICAL PRACTICE, by *Leonard E. Reisman,* M.D., and *Adam P. Matheny, Jr.,* Ph.D. (St. Louis, C. V. Mosby Company, 1969. $12.75).

Drs. Reisman and Matheny, of the Department of Pediatrics at the University of Louisville School of Medicine, intended this book primarily for the practicing physician who does not have a sophisticated knowledge of genetics and the background knowledge prerequisite for counseling patients concerning disorders which are possibly inherited. *The book does not contain a review of genetics, however, and readers should possess some elementary acquaintance with the subject before consulting it.*

The book is divided into 14 chapters, including the tools of genetics counseling all the way through a systematic consideration of the known genetic abnormalities. The consideration of nuclear sexing and karyotyping is comprehensive as well as concise, and is well worth reading. Thereafter there are chapters which take up Down's syndrome, the autosomal chromosome abnormalities, the sex chromosome abnormalities, the sex link disorders, twins, heredity, blood groups, the inborn errors of metabolism, genetics in cancer, mental retardation, and future perspectives in genetic counseling. The common disorders which have chromosomal abnormalities are all presented concisely and are well illustrated. There are virtually no illustrations of genetic abnormalities in which there are no known chromosome abnormalities.

This book has several excellent features. In numerous tables there are compendia of the heritable abnormalities. They list the disease together with the mode of inheritance and the clinical or metabolic defects it produces. This is information which is difficult to come by in a single source.

The chapters on the chromosome abnormalities are the most lucid, probably because more information is available on them. In addition there are tables which give the risks of recurrence of certain defects. The chapter on genetics in cancer is a weak point in the book, but it is weak in most books because so little is known about the inheritance of cancer. The commonly accepted information on cancer inheritance is available in this chapter. The chapter on mental retardation is rather vague, probably because concrete scientific information is scarce and because much of the counseling is advisory and philosophical. However, concise information is presented on mental retardation, and the reader is offered several approaches to the counseling of parents regarding it.

I was able to detect very few errors. However on pages 95 and 96 there are manifest printing errors in the karyotypes illustrated. On page 95 the arrow points to a deletion of a G Group chromosome labeled "No. 21." Yet the description indicates that the deletion is in chromosome "No. 18." On page 96, the arrow points to a deletion of chromosome "No. 18." and the description indicates that the deletion is in chromosome "No. 21." It is apparent that the descriptions for these two karyotypes have been reversed.

This is a most useful and worthwhile book for a physician who wants to get practical information on the precise subject indicated by the title. Its greatest value is that it includes information which is hard to find elsewhere in a single volume.—*Alexander Ervanian,* M.D.

ATLAS OF HUMAN ELECTRON MICROSCOPY, by *Ruben P. Laguens* and *Cesar L. A. Gomez Dumm* (St. Louis, C. V. Mosby Company, 1969. $20.50).

This is an atlas of normal human election microscopy. The chapters in this book are similar to those in a standard histology textbook. However, all of these chapters contain electron photomicrographs of normal tissues. These photographs take up microscopy at the point where standard light microscopy ends.

The entire spectrum of normal tissues is covered on 85 pages of magnificent electron photomicrographs. Most pages contain two photomicrographs, but some contain only one large photograph and others contain three or four small photographs, depending upon the material being illustrated.

The photographs are well labeled, and a clear text adjacent to each photograph clearly explains the details.

Unfortunately, this magnificent atlas will probably be of use only to students of microscopic anatomy. They include undergraduate students as well as research and practicing pathologists.

To them, I can recommend it without reservations. —*Alexander Ervanian,* M.D.

BOOKS RECEIVED

MICRONEUROSURGERY, by *Robert W. Rand,* Ph.D., M.D. St. Louis, C. V. Mosby Company, 1969, $25.00).

PRACTICAL EVALUATION OF THE ELECTROCARDIOGRAM, by *R. Schroeder,* M.D., and *H. Suedhoff,* M.D. Translated by *William H. Wehrmacher,* M.D., from the third German edition of Praktische EKG-Auswertung, Differentialdiagnostisches Tabellarium. (Springfield, Charles C Thomas, 1969, $19.75).

BING'S LOCAL DIAGNOSIS IN NEUROLOGICAL DISEASES, Fifteenth Edition, by *Webb Haymaker,* M.D. (St. Louis, C. V. Mosby Company, 1969, $32.50).

CURRENT CONCEPTS IN OPHTHALMOLOGY, Volume II, by *Bernard Becker,* M.D., and *Ronald M. Burde,* M.D. St. Louis, C. V. Mosby Company, 1969, $21.00).

HANDBOOK OF OCULAR THERAPEUTICS AND PHARMACOLOGY, Third Edition, by *Philip P. Ellis,* M.D., and *Donn L. Smith,* M.D., Ph.D. (St. Louis, C. V. Mosby Company, 1969, $10.75).

ARROWS OF MERCY, by *Philip Smith.* (Garden City, New York, Doubleday & Company, Inc., 1969, $5.95).

FUNDAMENTALS OF INHALATION THERAPY, by *Donald F. Egan,* M.D. (St. Louis, C. V. Mosby Company, 1969, $11.00).

Iowa Chapter of the American Academy of General Practice

Annual Refresher Course for the General Practitioner

Iowa City
February 10-13

Tuesday, February 10

SYMPOSIUM ON EMERGENCY CARE

9:05 a.m. "The Patient in Shock"—Dr. E. E. Mason, Dr. A. R. Boutros and Dr. K. J. Printen
10:00 a.m. "Injured Hands"—Dr. A. E. Flatt
10:45 a.m. "The Stroke Patient"—Dr. N. P. Rossi, Dr. H. B. Locksley and Dr. J. R. Taylor
11:45 a.m. "The Burned Patient"—Dr. S. E. Ziffren and Dr. C. E. Hartford
12:30 p.m. LUNCH
1:00 p.m. CLINICAL MOVIES
1:30 p.m. "Management of Myocardial Infarction: Medical and Surgical Aspects"—Dr. L. E. January, Dr. Johann Ehrenhaft, Dr. R. J. Luchi and Dr. M. E. Korns
3:15 p.m. "Progress Report: Transplantation at the University of Iowa"—Dr. W. W. Bonney, Dr. H. S. Thompson and Dr. R. L. Lawton
4:00 p.m. "Cardioversion"—Dr. D. L. Warkentin
4:20 p.m. "Athletic Injuries to the Knee"—Dr. D. B. Kettelkamp

Wednesday, February 11

9:00 a.m. "Antibiotics: Use and Abuse"—Dr. I. M. Smith, Dr. Maurice Champion and Dr. Sergio Rabinovich
9:40 a.m. "Cardiac Pacemakers: Their Care and Feeding"—Dr. Rossi and Dr. Warkentin
10:30 a.m. "Management of Acute Gastrointestinal Bleeding"—Dr. J. A. Clifton and Dr. W. L. Zike
11:00 a.m. SMALL-GROUP CONFERENCES
- A. "Radiation Therapy, New Instruments and Concepts"—Dr. H. B. Latourette
- B. "Clotting Disorders"—Dr. J. C. Hoak and Dr. E. D. Warner
- C. "Farm Injuries"—L. W. Knapp, Jr., Ph.D., and Dr. C. B. Larson
- D. "Test-taking for Board Examinations"—Dr. R. M. Caplan

11:45 a.m. SMALL GROUP CONFERENCES
- A. "Anti-cholesterol Agents"—Dr. A. A. Spector
- B. "Obesity"—Dr. W. A. Krehl
- C. "Plastic Repair of Facial Lacerations"—Dr. Leslie Bernstein
- D. "Nuclear Medicine"—Dr. J. Christie

12:30 p.m. LUNCH
1:15 p.m. CLINICAL MOVIES
2:00 p.m. "Workup and Treatment for Hypertension"—Dr. W. M. Kirkendall, Dr. D. A. Culp and Dr. W. R. Wilson
3:30 p.m. "Management of Disc Syndromes"—Dr. Larson
4:15 p.m. "Useful Physiotherapy in Arthritis"—Dr. M. P. Strottman
8:00 p.m. MEETING OF FAMILY PRACTICE CLUB

Thursday, February 12

9:05 a.m. "Pyelitis in Pregnancy"—Dr. C. A. White, Jr., and Dr. Culp
9:30 a.m. "Complications of the Third Trimester"—Dr. C. P. Goplerud
10:30 a.m. "Postpartum Psychosis"—Dr. R. M. Kretzschmar and Dr. A. S. Norris
11:00 a.m. SMALL-GROUP CONFERENCES
- A. "Drug Treatment of Cancer"—Dr. H. P. Gulesserian
- B. "Test-Taking for Board Examinations"—Dr. Caplan
- C. "Noise Trauma: Farm and City"—C. V. Anderson, Ph.D.
- D. WORKSHOP IN OPHTHALMOSCOPY AND TONOMETRY (limited to 20)—Dr. B. E. Spivey *et al.*

11:45 a.m. SMALL-GROUP CONFERENCES
- A. "Diagnosis of Breast Disease"—Dr. R. D. Liechty
- B. "Clinical Pharmacology of Diuretic Agents"—Dr. Wilson and Dr. V. S. Aoki
- C. "Clinical Uses of Neuromuscular Blocking Agents"—Dr. M. D. Sokoll
- D. WORKSHOP IN OPHTHALMOSCOPY AND TONOMETRY (limited to 20)—Dr. Spivey *et al.*

12:30 p.m. LUNCH (opportunities for three 20-physician groups to "lunch with the experts")
1:15 p.m. CLINICAL MOVIES
2:00 p.m. "Contact Lenses: Why, Who, When, How?"—Dr. Charlotte A. Burns
2:30 p.m. "What's New in Managing Common Dermatoses"—Dr. C. E. Radcliffe
3:00 p.m. "Vertigo in the Elderly"—Dr. A. L. Sahs and Dr. B. F. McCabe
3:50 p.m. "Drug Therapy for Parkinsonism"—Dr. R. W. Fincham
4:20 p.m. "Teenage Drug Abuse"—Dr. E. F. Rose, Dr. R. J. Bittle and Dr. David P. Carew

Friday, February 13

9:00 a.m. "Detection of Learning Disorders"—Dr. C. Johnson, Dr. G. R. Alley and J. Anderson, Ph.D.
9:35 a.m. "Speech and Hearing Impairment"—Dr. W. B. Litton and Dr. J. K. Smith

(Continued on page 44)

INFORMATION FROM THE
IOWA HEART ASSOCIATION

Prosthetic Replacement of the Mitral Valve

An Assessment of the Clinical and Hemodynamic Results of Operation

ANDREW G. MORROW, M.D.

THE STARR-EDWARDS prosthetic mitral valve has provided the surgeon a means for correcting mitral valve malformations that are not otherwise amenable to operative treatment. These malformations may be generally classified as rheumatic mitral regurgitation and calcific mitral stenosis, although in rare instances valve replacement is required in a patient with congenital heart disease. In many other patients with pure or predominant mitral stenosis, the valve may retain reasonable mobility and remain free, or nearly free, of calcification. In such patients—they usually are young women in regular sinus rhythm—relief of obstruction can be achieved by digital or instrumental mitral commissurotomy, and this safe and simple closed operation should be employed whenever possible. In contrast, when a stenotic valve and the supporting subvalvular structures are heavily calcified and densely fibrotic, effective function can almost never be restored, even by debridement and commissurotomy under direct vision. In this clinic the results of reconstructive operations for mitral regurgitation have also been poor. Moderate to severe regurgitation has recurred in virtually all patients after one or two years, even though the valve was competent during the early postoperative period.

The Starr-Edwards prosthesis has been utilized at the National Heart Institute since 1961, and it has been inserted in more than 300 patients. The early and late results of operative treatment in 100 consecutive patients were recently reviewed, and they will be summarized in this report.

THE PATIENTS

All 100 patients had acquired mitral valve disease, and two thirds of them gave clear histories of previous rheumatic fever. Fifty-three were females and 47 males, and they ranged in age from 10 to 64 years, their mean age at operation being 38 years. All patients were distinctly symptomatic, and 34 were in Class IV (NYHA); 64 in Class III; and 2 in Class II. Eighty-seven patients had required hospitalization for the treatment of congestive heart failure on one or more occasions, and 38 had been hospitalized three or more times. Previous operations had been performed on the mitral valve in 35 patients.

The characteristic clinical, radiographic and electrocardiographic findings of mitral stenosis, mitral regurgitation or combined mitral valvular malformations were evident in each patient. Signs of tricuspid regurgitation were also present in 36 patients, and 24 patients had physical evidence of aortic regurgitation, but of insufficient severity to necessitate aortic valve replacement. Calcification of the mitral valve was evident fluoroscopically in 63 patients.

All of the patients were studied by right-, and 95 by left-heart catheterization preoperatively. On the basis of the preoperative hemodynamic and angiographic assessments and the operative findings, 50 patients were judged to have pure or predominant mitral stenosis, and 50 were thought to have pure of predominant mitral regurgitation. In the entire group of 100, severe pulmonary hypertension (systolic pressure $\geqq$ 50 mm. Hg) was present in 69 patients, and the average cardiac index was reduced to 2.1 liters per minute per square-meter of body surface. Preoperatively the left atrial mean pressure had been abnormally elevated in 96 patients (average: 22 mm. Hg). A diastolic gradient across the valve was recorded in every patient with mitral stenosis, and in 33 of those with mitral regurgitation.

THE OPERATION

In most instances the operation was performed through a left lateral thoracotomy (with right-ventricular cannulation for venous return), and in the remainder a median sternotomy or right thoracotomy was employed. Cardiopulmonary bypass was usually conducted at 37°C., but a mild general hypothermia (30°C.) was induced when aortic regurgitation necessitated numerous or prolonged periods of aortic occlusion. Ventricular fibrillation was induced in most patients by A.C. stimulation.

When the necessity for valve replacement had been determined, the valve was excised in continuity with the chordae tendineae and papillary muscles. Residual calcific deposits in the annulus were removed with a rongeur, and the ventricle was lavaged. The prosthetic valves employed were those supplied by the Edwards Laboratories at the time, and all had bare metal orifices and struts, and silastic poppets. Size 3M or 4M valves

Dr. Morrow is chief, Clinic of Surgery, National Heart Institute, Bethesda, Maryland.

were inserted in 90 patients, but nine received 2M valves, and one a 5M. The valves were anchored by means of 15 to 20 interrupted sutures, each passed twice through the fixation ring of the prosthesis and the patient's valve ring. A left atrial thrombus was present in 17 patients, and was excised prior to valve replacement. In six of these, calcification of the left atrial wall was evident preoperatively.

For 12 to 24 hours during the immediate postoperative period, assisted ventilation was provided via the endotracheal tube, and in 34 patients tracheostomy was performed because longer periods of assistance were required. Warfarin anticoagulation was instituted 48-72 hours after operation.

THE RESULTS

Immediate Mortality. Of the 100 patients, 17 (17 per cent) died during the hospitalization during which valve replacement was carried out. Two patients died in the operating room; one had uncontrolled bleeding from the atrium, and in the other it was impossible to restore effective cardiac contractions after bypass. Eight patients died between one and seven days after operation with progressive hypotension and signs of reduced cardiac output. All had normal or small left-ventricular cavities. At necropsy it appeared that obstruction to left atrial outflow had been produced by incomplete descent of the prosthetic ball. That failure, in turn, had resulted from protrusion of the muscular ventricular septum into the cage. In five of the eight patients, massive thrombosis of the valve and atrium had occurred. Two other patients died of acute myocardial infarction—one as the result of a coronary arterial embolus. One patient died of cerebral embolism from air trapped in the atrial appendage, and another from infected pulmonary emboli which had been present preoperatively. The remaining three patients—all young women with mitral regurgitation—died one or two days postoperatively, after evidencing cardiac failure and hypotension. No anatomic cause of death was evident at necropsy.

Late Mortality. Seven of the 83 patients who survived the immediate postoperative period died between five and 24 months later. Two had infectious endocarditis; in one patient the infection followed an intercurrent operation performed without the administration of antibiotics. One patient sustained a fatal cerebral embolus after her physician had stopped warfarin administration for undisclosed reasons. Another patient had a subarachnoid hemorrhage as a result of warfarin overdosage. One patient died in heart failure after an unsuccessful attempt to close a peribasilar fistula. In the remaining two patients death was sudden and unexpected, and the cause is unknown.

Thromboembolism and Anticoagulation. An attempt has been made to maintain all patients on therapeutic doses of warfarin, but this aspect of the patients' management has been under the control of the referring physicians. Nine patients have sustained definite cerebral emboli, and in two of them cerebral embolism has occurred on two different occasions. As noted above, one of the cerebral-embolism patients who was not receiving warfarin died. Another has persistent flaccid hemiparesis and is severely incapacitated. In two patients neurologic abnormalities have been found on examination, but they are asymptomatic. The other five patients who had cerebral emboli have no detectable abnormalities. Five additional patients have described transient vertigo, amnesia or muscular weakness, but no neurologic abnormalities have ever been detected in them during any examination.

One patient died as the result of warfarin toxicity, and two others have had massive but nonfatal episodes of gastrointestinal bleeding.

Clinical Status. The 76 surviving patients have been followed for periods ranging from two to six years. Forty-seven of them (62 per cent) are asymptomatic (Class I); 26 are in functional Class II; and 3 are in Class III. Preoperatively, 52 of those 76 patients were in Class III; and 23 were in Class IV. Fifty-three patients (70 per cent) are working full time or, in the cases of some women, are managing their homes and families without unusual assistance. Sixty-nine patients (92 per cent) are on unrestricted diets.

Postoperative Hemodynamic Assessments. The resting pulmonary arterial pressure was lower postoperatively in every patient in whom it had been abnormally elevated before operation, and the systolic pressure was less than 50 mm. Hg in 71 of 74 patients studied. The left atrial mean pressure was also reduced in every patient in whom it had been abnormal, but in 15 of 68 patients it still exceeded 12 mm. Hg. The cardiac index was higher postoperatively in 63 of 67 patients, and the average postoperative value was normal, 2.9 L./min./M^2.

SOME CONCLUSIONS CONCERNING MITRAL VALVE REPLACEMENT

The experience with mitral valve replacement in these and other patients allows certain conclusions concerning the present status of the operation, and permits some predictions as to its future applicability. The immediate operative risk continues to approximate 10 per cent, and it will probably not become significantly lower as long as the operation is reserved for severely ill patients—those in Classes III and IV. The Starr-Edwards prosthesis is the subject of constant reevaluation and improvement, and as the long-term reliability of the valve improves, the operation reasonably can and should be recommended to patients earlier in the courses of their diseases. The incidences of death and disabling complications in the late postoperative period have thus

far been distinctly lower than in patients with prosthetic aortic valves. Arterial emboli have occurred in about one-fifth of patients, in spite of all attempts to maintain effective anticoagulation with warfarin, but significant sequelae of the emboli have been absent or inconsequential in all but two patients. Improved prostheses can be expected to eliminate or greatly reduce the incidence of thromboembolism.

Of greatest importance is the fact that surviving patients have experienced striking and sometimes dramatic symptomatic improvement, and almost all have been able to return to useful and productive lives, and to carry on their increased activities without significant discomfort. The postoperative hemodynamic studies have shown that symptomatic improvement is paralleled by a return of the cardiac output and intracardiac pressures to normal or near-normal levels.

Doctors' Fees Just Ten Per Cent of Medicaid Costs in Minnesota

In one of its miscellaneous notes collectively subtitled "Briefs" at the bottom of its "Tax Report" column on December 10, the WALL STREET JOURNAL said: "The Minnesota Taxpayers Association says doctors' fees made up only 10 per cent of the $96.5 million spent on medical assistance to the needy in the state the last fiscal year. Nursing homes were paid 49 per cent, and hospital services took 24 per cent."

In the same column, the newspaper reported on a court case involving the tax status of a "professional corporation" in Wisconsin. It will be of interest to Iowa physicians who contemplate reorganizing their clinic groups if and when the General Assembly of Iowa adopts the requisite enabling legislation. "Professional corporations," it said, "must be corporate in fact as well as form.

"Last August the Treasury dropped its protracted opposition to accepting professional service corporations as corporations for Federal tax purposes. Doctors in particular have been eager to gain tax benefits by incorporating. Now a Tax Court decision makes it clear that such benefits by no means follow automatically. Such endeavors must 'put flesh on the bones of the corporate skeleton.'

"The case involved four radiologists who set up a corporation under Wisconsin law. The men had separate practices in their own names before they incorporated, and their practices were largely unaffected thereafter—except that all of their fees and expenses were paid into or from the corporation's checking accounts. Each doctor was credited with what he earned, and docked for what he spent.

"The Court said the income couldn't be taxed to the corporation because it did nothing to earn it. It sold no services, owned no equipment and exerted no real control over its 'employees.' 'A mere set of bookkeeping entries and bank accounts!' the Court said."

Annual Refresher Course for the General Practitioner

(Continued from page 41)

10:25 a.m. "Glomerulonephritis"—Dr. Donal Dunphy, Dr. G. B. Theil, Dr. H. B. Richerson and Dr. I. S. Snyder

11:00 a.m. SMALL-GROUP CONFERENCES

A. "Respiratory Emergencies in the Newborn"—Dr. Dunphy

B. "Management of Hemorrhoidal Complaints"—Dr. Lawrence DenBesten

C. "Evaluation and Treatment of Hyperthyroidism"—Dr. H. E. Hamilton

D. "Dealing with Death and Dying"—David Belgum, Ph.D.

11:45 a.m. SMALL-GROUP CONFERENCES

A. "Management of the Rh Problem"—Dr. White

B. "Depression: Recognition and Control"—Dr. Garfield Tourney

C. "Life-Support Systems: I.C.U. Experience"—Dr. Boutros

D. "Dermatologic Questions and Answers"—Dr. W. C. Fritsch

12:30 p.m. LUNCH

1:00 p.m. CLINICAL MOVIES

1:30 p.m. "The Status and Prospects for Family-Practice Programs at the U. of I."—Dean W. O. Rieke

2:00 p.m. "Office Assessment of Respiratory Function"—Dr. Richerson and Dr. D. C. Zavala

2:20 p.m. "Management of Bronchial Asthma"—Dr. J. M. Smith and Dr. Richerson

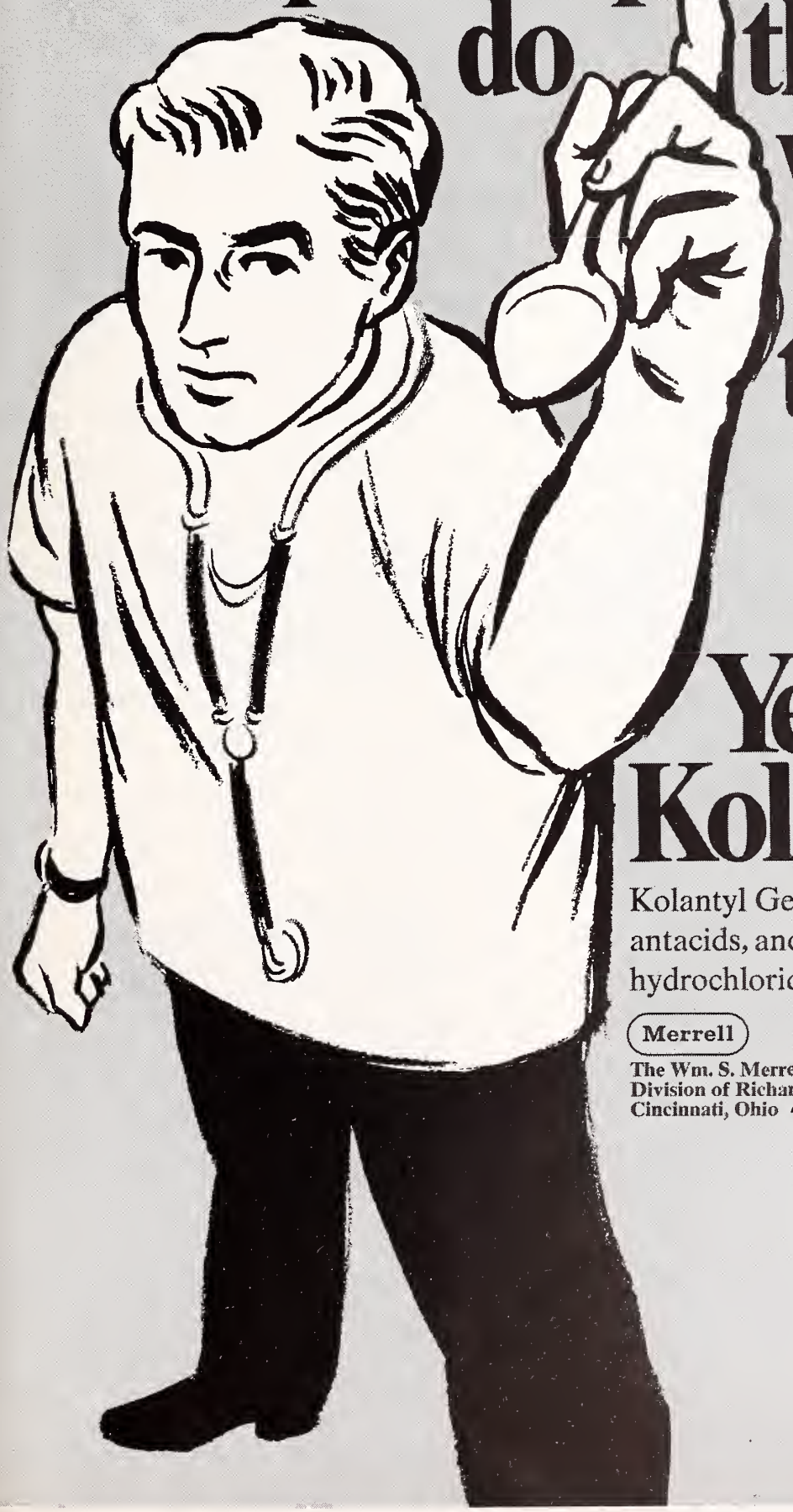
3:30 p.m. "What Can We Offer the Diabetic?"—Dr. J. D. Brown, Dr. Montague Lawrence, Dr. Robert C. Watzke and Dr. Theil

Conference on Infectious Diseases at Madison

The Departments of Postgraduate Medicine and of Pediatrics at the University of Wisconsin Medical School will offer a 2½-day conference on infectious diseases, March 12 to 14, in Madison. The guest speakers will include Dr. Donald N. Medearis, Jr., dean of the University of Pittsburgh Medical School; Dr. David H. Carver, an associate professor of pediatrics at Johns Hopkins; Dr. Martha Yow, a professor of pediatrics at Baylor Medical School; Dr. David Smith, an associate professor of pediatrics at Harvard; and Dr. Eli Gold, a professor of pediatrics at Case-Western Reserve.

For further information, write to Thomas C. Meyer, M.D., chairman, Department of Postgraduate Medicine, 307 North Charter, Madison, Wisconsin 53706.

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Iowa Association of Medical Assistants

What About 1970? ? ? ?

The New Year is well under way. The Holiday Spirit has somehow dwindled, and day-to-day problems once again have settled on our shoulders. Rather than discuss resolutions, as we are prone to do, how about some constructive planning?

Some time ago I came across an article prepared by social researchers which concerned the incentives and gratifications to be found in an occupation or a profession. It may surprise you to learn that *interesting work, opportunity for advancement, recognition,* and *opportunity to learn or use ideas* have been found to rank very high, along with *security,* among the factors that make people enjoy their jobs. *Hours, ease of job* and *fringe benefits* were at the bottom of the list!

I know of no better food for medical assistants' thought! We have constant opportunities to learn, to create, to contribute and to earn recognition. There is a sense of satisfaction in learning to do something and in doing it well, and most people are happier when a job demands more than sheer endurance.

Strive to increase your knowledge of your work and your skill in doing it. Set a goal for yourself, and if you reach it quickly, set other and higher ones. Study and prepare for the opportunity to become certified. Good relations with your colleagues are especially important. Get to know them well through your Medical Assistant Association meetings. You will find your work more enjoyable because of your friendships when you have occasion to correspond with other medical assistants in the course of your duties.

You need to contribute something! How many times have we heard: "I'm not getting anything out of my membership." Are the members who voice such complaints making use of the many advantages that have been offered to them? Are they takng active parts in the work of the Association on local, state and national levels? Do they attend the seminars and conventions that have been planned especially for them? Do they read the PROFESSIONAL MEDICAL ASSISTANT? If the answer is "no," they indeed are not benefiting from their membership. Yet they are missing out on the best part of their work by neglecting these opportunities.

So what about 1970? It isn't too soon for you to mark your calendar for the state convention to be held in Waterloo during the third weekend in May, and for the national convention, which is to be held in Des Moines this year, on October 25-31, 1970.

In this section of a recent IMS JOURNAL, an announcement was made concerning the AMA's approving an educational program for girls who wish to become medical assistants. It might be said that this milestone marks the close of the pioneer era of medical assisting. More and more, we are coming to the time when a person applying for work in a doctor's office can be expected to have had some formal preparation. The benefits to the doctor will be obvious. He will no longer need to spend time providing basic training to his new employees. The AMA's guidelines are intended to provide a broad general outline for such training —training that will assure the physician that the person he hires is qualified.

The program is to constitute a two-year course at the junior-college level, concluding with the awarding of the "associate in arts" degree. The basic curriculum is to consist of the following:

1. Anatomy and physiology
2. Medical terminology
3. Medical law, ethics and economics
4. Psychology
5. Medical assistant administration procedures —including patient-reception; appointment scheduling; telephone techniques; handling mail, medical records, business correspondence and insurance forms; medical dictation or machine transcription; office-management practices; record-keeping and financial records; accounting; and preparing of statements.
6. Medical assistant clinical procedures—including examination-room techniques; practices and techniques in sterilization; and care of equipment and supplies.
7. Laboratory orientation—including basic knowledge of the purposes and techniques of the laboratory procedures performed most frequently in a doctor's office.
8. Externship. A review and rotation sequence of practical experience in the offices of qualified physicians, or in accredited hospitals selected by the school.

In addition to this basic curriculum, the stu-

dent's education is to include a study of the humanities and social sciences.

This two-year program represents the AAMA's major effort at developing educational standards for the fully-qualified medical assistant. A number of schools were surveyed, and an evaluation of the medical-assistant program at each of them was submitted to the AMA. At present, the following have been accredited:

1. San Antonio College, San Antonio, Texas
2. West Valley Junior College, Campbell, California
3. Modesto Junior College, Modesto, California
4. Pasadena City College, Pasadena, California
5. Cuyahoga Community College, Cleveland, Ohio.

The work of the AAMA Approval, Education and Certification Committees would have progressed at a much slower pace, had it not been for the generous contributions of many thousands of dollars, especially for these programs, by Lederle Laboratories, and by Merck, Sharp & Dohme.

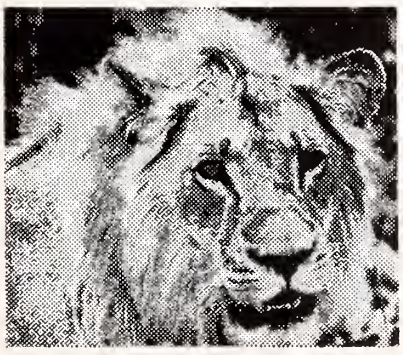
—JEANNE D. GREEN

The AMA Offers to Lend a New Film on the Role of the Medical Witness

A new motion picture, "Next Witness," has replaced "The Medical Witness," which a great many—perhaps a majority—of physicians have seen. It is designed to show physicians what may be expected of them if they have occasion to testify as a medical witness in personal-injury litigation. The new film is of particular value because about 70 per cent of all court actions deal with personal-injury claims, often requiring a physician's testimony.

"Next Witness," 16 mm., sound and color, stresses the importance to both the physician and the attorney of pretrial preparation for the medical witness. The story line shows how a lack of preparation can create awkward and embarrassing situations in court. It can be borrowed from the AMA Film Library, 535 North Dearborn Street, Chicago 60610.

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Sales and Use Taxes Payable by Physicians

On October 30, 1969, the Iowa Department of Revenue sent a letter to Iowa physicians requesting them to make a "self-audit" of their Iowa use-tax payments for the past five years.

The letter pointed out that approximately 10 years ago the Iowa Tax Commission initiated an audit program directed toward the professional practitioners. According to the letter it has recently been suggested that this program be reinitiated.

Currently, Iowa has three 3-per-cent taxes on (1) sales, (2) use and (3) services. The last of these is inapplicable to the services of physicians. The sales tax applies to retail sales. The use tax complements the sales tax and is a tax on the "use" of property, but no use tax is, in fact, payable if the taxpayer has paid a sales tax.

THE TYPICAL PHYSICIAN

The physician who dispenses nothing other than his professional services is not required to charge or collect any tax from his patient. Accordingly he needs not obtain a sales-tax permit and make accountings to the State Department of Revenue.

However all physicians purchase equipment, supplies, drugs and other products in connection with their practices. Iowa suppliers are required to collect an Iowa sales tax at the time the physician pays for goods of this sort. If he pays the sales tax at that point, he is required to pay no use tax. It is only in those cases where the physician buys goods, etc., from an out-of-state supplier that a possible problem concerning the use tax arises. If, in fact, the out-of-state supplier collects either the Iowa sales or use tax, the physician has no further liability regarding that transaction. Or if the out-of-state supplier collects a sales or use tax of 3 per cent or more on behalf of another state, the physician has no further tax obligation. If the tax so collected is less than 3 per cent, however, the physician is supposed to take credit for the tax he paid to the supplier and to pay the difference to the Iowa Tax Commission.

The "self-audit" of the Iowa Department of Revenue is designed to get at purchases by Iowa physicians of equipment, supplies, drugs, etc. on which neither a 3 per cent sales tax nor a 3 per cent use tax has been paid. The "self-audit" begins:

"This being the first, or mail phase, please check the applicable statement:

() I receive the Consumer's Use Tax Return each quarter and report and remit.

() My reporting number is -UT- .

() I do not purchase out-of-state."

The typical physician would check neither of the first two statements, since he has had no obligation to obtain a reporting number or to file quarterly use-tax returns. If he does not purchase out-of-state, he should so indicate, and this will pretty well free him from a further audit. However he is asked to give the names and addresses of his "Iowa suppliers," and presumably his answer permits the Tax Commission to make certain that those suppliers are charging and collecting the Iowa sales tax.

The next item on the "self-audit" is as follows:

"() I do buy out-of-state and do pay the Iowa tax to the suppliers, who are:"

This permits the physician to list the names of out-of-state suppliers to whom he has paid the Iowa sales or use tax, or another sales or use tax of comparable amount.

The remaining item on the "self-audit" states:

"() I have bought out-of-state, not accounting for Iowa sales or use tax."

It is only at this point that the Iowa physician has any responsibility to account for and pay the Iowa use tax.

The Iowa Department of Revenue contends that any purchases made by the physician during the preceding five years, whether of a personal or a business nature, are subject to the Iowa use tax if no tax was, in fact, paid on these purchases. Theoretically, the physician himself is the "ultimate consumer" of the "tangible personal property" purchased for use in Iowa. The simplest thing for the physician to do is to have his invoices from out-of-state suppliers checked, to complete the "self-audit" and the "consumer's use-tax return," and to pay any 3 per cent use tax that may be due. Thereafter he is required to file a "consumer's use-tax return" only for any quarter in which he has made out-of-state purchases on which no tax was paid.

Clearly, equipment such as an x-ray machine would be subject to the Iowa use tax if no other tax had been paid on the purchase. However a problem still remains with regard to consumable supplies which become component parts of the professional services he provides to patients. It may well be contended that the patient, not the physician, is the "ultimate consumer" of bandages, vaccines, medications, etc., and that since there is no tax on professional service, the physician is required to pay no tax at the time of his purchase of such commodities. The consumer's use-tax return (UT-510) contains an instruction under the heading "Computation of Tax" on page 4 beginning at line 1 which lends some weight to this conclusion:

"This figure need not include purchases made for the purpose of resale by you in the regular

course of business, of raw material which by your fabrication, compounding, manufacturing or servicing become a component part of the finished product to be ultimately sold at retail."

This instruction is at least confusing as applied to physicians. It is apparently intended to explain the following, which appears on page 4 of the tax return under the heading "Exemptions":

"The following purchases are exempt from tax under the provisions of the Act: . . . 'Purchases for purposes of processing as defined in paragraph 1, Section 423.1, Chapter 423, 1966 Code of Iowa, as amended.'"

Although this ambiguity in the law and in the instructions poses an interesting legal problem, IMS legal counsel recommends that unless the amount of tax is substantial it is better to acquiesce to the Department's regulation that the physician is the consumer of such property, and that a sales or use tax is payable at the time he purchases it.

In summary, it is recommended that physicians complete the "self-audit" received from the Department of Revenue. No tax will be due and payable unless the physician has purchased tangible personal property from an out-of-state supplier who charged neither a sales or use tax of the amount required in Iowa. The easiest thing for the physician to do is to pay the tax with interest, as indicated by the audit and the "consumer's use-tax return." If a physician were to omit items which have become component parts of the medical service he has rendered, he would be acting contrary to the instructions of the Department of Revenue. The physician is under no obligation to continue filing quarterly returns except for those quarters in which a use tax is in fact due and payable.

THE DISPENSING PHYSICIAN

Physicians who dispense "drugs, medicines and other items to their patients and others" have the same problems with respect to the Iowa use tax, but in addition they must consider some others. If a physician sells and dispenses drugs or other commodities as would a pharmacy or any other retailer, he becomes a "retailer" under the Iowa sales-tax law, and should obtain a sales-tax permit and make regular accountings, reports and remittances to the Department of Revenue. This type of property is "tax exempt" when purchased by the physician, but he must charge a sales tax to the patient and must remit it in connection with its sale to the patient as the "ultimate consumer."

A special problem exists if "dispensing physicians" consume "the same type of personal property that they also sell at retail." Inasmuch as the property was purchased on a "tax exempt" basis, a dispensing physician is supposed to account for that portion of the property which he has consumed, and to pay a use tax on it.

The dispensing physician is not necessarily a "retailer" if the drugs, appliances, etc. are used as parts of the professional service he renders to the patient. Rule 89 points up the distinction between professional services and "retail sales," and that distinction should be applicable to physicians generally:

"89. *Oculists, ophthalmologists, optometrists and opticians.* Oculists, ophthalmologists, optometrists and opticians render professional services with their receipts exempt from sales tax. They are, however, the consumers of ophthalmic materials including eyeglasses, contact lenses, frames and lenses used or furnished in the performance of this service work. Tax, therefore, applies on all items acquired for this work.

"If oculist, ophthalmologists, optometrists or opticians sell tangible personal property in addition to rendering their professional services, they must hold a retail sales tax permit and report all sales tax due from their retail sales."

Rule 89 is favorable to physicians in that it gives a broad interpretation to the concept of "professional service," and apparently leaves as "retailers" only those physicians who actively sell drugs or other "tangible personal property in addition to rendering their professional services." Those few physicians who come within this definition of "retailer" should obtain instructions from the Department concerning the procurement of a retail sales-tax permit, etc. Other "dispensing physicians" who dispense in connection with the rendition of professional services, appear to be subject to the same considerations as the "typical physician."

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

A most worthwhile mechanism for creating a memorial to a relative, associate, colleague or friend exists in the Scanlon Medical Foundation/Iowa Medical Society. The Foundation utilizes memorial gifts to carry forward its loan program which has helped more than 300 young Iowans finance their medical educations. The Foundation will be glad to send an appropriate card in the name of the donor to the family of the person honored. The tax-deductible memorial gifts should be directed to the Scanlon Medical Foundation/ Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

THE DOCTOR'S BUSINESS



The Costs of Medical Practice

LARRY E. LEAVERTON
Des Moines

Just about everything one hears or reads today about medical care includes the word *cost*. The cost so mentioned usually is that borne by the recipients of this care. Frequently neglected or not mentioned is the cost borne by the *provider* of this care.

When the public or communications media say that Doctor X received so much in a year from Medicare or Medicaid, or that Doctor Z charges so much per hour for his time, most persons assume that the figure represents the physician's net or "take home" earnings. The average physician, on the contrary, whether he is in solo practice or in a group, pays out 35 to 45 per cent of his gross income for operating expenses.

Why does it cost so much to maintain a medical practice?

The costs of establishing and maintaining a medical practice vary with the specialty and the community. An internist with a large practice who delegates as much responsibility as he can will have a larger office layout and more employees than will the general surgeon or any of the surgical specialists who do much of their work in hospitals. A general practitioner in a small Iowa community will have different expenses from those of his colleagues in Des Moines, Sioux City or Cedar Rapids.

It is not surprising that operating expenses are higher in the large cities. Almost everything costs more there. Fees charged to patients are likewise higher.

Speaking in general—as one must when dealing with averages—we must say that the large groups frequently have higher operating expenses *per doctor* than does the small group or the solo practitioner. The causes may include a more elaborate office, expensive equipment, more employees and higher administrative expenses. The average general practitioner today spends $28,000 to $30,000 for operating expenses. The specialist spends slightly less, or $24,000 to $28,000, because many such men have smaller offices and make greater use of hospitals. Nineteen years ago, in 1950, the average established general practitioner spent an average of just $15,800 to operate his practice. Ten years ago, in 1959, the average had climbed to $21,900.

The two major items of expense—rent and salaries—show considerable variance from small communities to large. Rent in metropolitan areas runs from $4 to $6 per square foot per year. For an average-size office of 1,000 square feet, the rent is $6,000 per year, or $500 per month. In small communities rent averages just $3 to $4 per square foot per year. The average general practitioner spends $10,000 to $11,000 per year on salaries, and the specialist spends $5,000 to $10,000. Whether in solo practice or in groups, there usually are more than two employees per doctor. In future years, with added emphasis upon delegation of responsibilities, this could increase to three employees per doctor.

There are other costs of a medical practice which must be considered. Utilities, supplies, meetings, dues, journals, car and other travel, business taxes, business insurance, and depreciation on equipment are some of the items.

WAYS OF REDUCING THESE COSTS

We are frequently asked: "What can be done to hold down these costs, and still provide quality care?"

Many expenses such as rent and salaries are irreducible. If one is going to have an attractive and efficient office and capable employees, one must pay for them. We think the key words are *efficiency* and *productivity*. Many physicians can be more efficient and more productive. For example, they can effect better scheduling of appointments and institute improved routines and procedures within their offices. Better delegation of tasks to qualified, well-trained personnel will

Mr. Leaverton has been associated with Professional Management Midwest since 1949. He is a partner in the firm, and is director of its Research and Development Department.

augment productivity without sacrificing quality. It has been estimated that a 3 per cent increase in productivity by the physicians in practice today could increase the effective supply of physicians by the equivalent of one year's medical-school graduates.

Quality medical care cannot be separated from the cost of providing it. Quality medical care means the best possible care at the least possible cost in time and money.

Don't forget the *patient's* time. Some physicians do. By keeping a patient waiting, they can be doubling *his* medical expense.

Statement Regarding Rubella

Issued by W. M. Krigsten, M.D.
President, Iowa Medical Society

The preventive or protective aspects of health care constitute a great challenge to our entire population. In Iowa and across the nation each and every citizen has a responsibility in his own interests, and in those of his family and community to seek out, understand and take advantage of every available protective health measure.

We are all aware of the advances which have occurred over the years in communicable disease control. The development of various vaccines has had a dramatic impact on the health and well being of the population. We now have before us another significant scientific breakthrough. A new vaccine, this for rubella or German measles, has become available just this summer. In all likelihood, widespread use of this vaccine will eradicate the disease, and more importantly, eliminate the serious manifestation which it produces in pregnant women.

It should be clearly understood that rubella is generally a mild disease when contracted during childhood. In postpubertal individuals, however, particularly females, there is considerably greater potential for harm from the disease. In these older persons illness is often more serious and prolonged and not infrequently has complications such as arthritis, arthralgia, and rarely, encephalitis. And when rubella is present during pregnancy, especially during the first trimester, from 15 to 35 per cent of the infants may be born with what is now known as congenital rubella syndrome. This syndrome manifests itself in partial or total loss of hearing or vision, major heart defects, mental retardation, or combinations of these defects. In addition, there is a significantly increased proportion of miscarriages and stillbirths.

We were pleased to learn of the licensing of the first rubella vaccine this past June, following a stepped up period of testing. While the vaccine is available now in limited quantity, it is expected that millions of doses will be available before next spring.

In attesting to the efficacy of any new drug, medication or vaccine, the Iowa Medical Society must place reliance on safeguards utilized by the manufacturer, the federal government and organizations such as the American Medical Association and the American Academy of Pediatrics.

According to the Council on Environmental and Public Health of the AMA, the vaccine was tested on over 13,000 susceptible children prior to licensing. In this testing there have been essentially no adverse reactions. However, because the vaccine is relatively new, the AMA Council has warned it is possible that unanticipated adverse reactions, particularly in older persons, may occur with general use of the vaccine. The Council advises the prompt reporting of any serious reaction.

Public health officials are now encouraging a prompt and broad rubella immunization program. The desire is to immunize as many children (between ages one and 12) as possible during the 1969-1970 school year. The urgency exists because of the cyclical nature of rubella. The disease has been found to occur in cycles of approximately seven years, with the early 1970's anticipated as the next epidemic period. In the last major epidemic year, 1964, an estimated 20,000 to 30,000 infants were born with severe defects. These factors have caused the State Department of Health to urge the conduct of mass immunization clinics in Iowa counties prior to the close of the 1969-1970 school year. The degree to which child-bearing women are exposed to the disease will be reduced sharply with the broad administration of the vaccine.

Support for this increased immunization activity has come from the Iowa Chapter of the American Academy of Pediatrics and from the Committee on Maternal and Child Health of the Iowa Medical Society. Under the existing policy of the Iowa Medical Society, the conduct of a mass immunization program is permissible, provided that it has the approval of the concerned county medical society. It is the belief of the Iowa Medical Society that local physicians, working within the framework of a county medical society, are most qualified to determine the best methods of providing preventive, diagnostic and therapeutic health care. County societies recognize they have a responsibility to assure that, to the fullest extent possible, such preventive health measures as immunizations are provided to the highest feasible percentage of the population. The manner in which this is done should be determined by local physicians.

The factors which have been enumerated here justify consideration by the county medical societies of a local rubella immunizaton program. We know a number of county societies have already established their plans and are working cooperatively with public health officials.

Doctor, after all we've been through together...

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Rocky Mountain spotted fever
scarlet fever
septicemias
sinusitis
soft tissue infection
tonsillitis
tularemia
typhus fever
urethritis

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Contraindications: Hypersensitivity to tetracycline.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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STATE DEPARTMENT OF HEALTH



JAMES F. SPEERS, M.D., M.P.H., COMMISSIONER

Farewell From Dr. Speers

As I prepare to leave the State of Iowa, it seems appropriate for me to review some of the events of past years, to attempt assessing the present state of affairs, and to make some recommendations for the future. I should like to approach this assignment from a dual viewpoint—as Commissioner of Health, but also as a member of the Iowa Medical Society. These two viewpoints, while different, are in no way conflicting. The ultimate goal of the medical profession is better health for the people of Iowa. The same can be said for the State Department of Health. It is not surprising, then, that close cooperation between the Department and the Iowa Medical Society has existed for many years.

I first came to Iowa in 1957. Since then, much progress has been made. Poliomyelitis and rubeola, through intensive immunization efforts by private practitioners and public health departments, have been virtually eliminated as causes of disability and death. The philosophy held by both the Medical Society and the Health Department—that health programs should be subject to local self-determination—has been embodied in the Local Health Act of 1967. This Act requires that there be a physician member on each local board. In the face of many difficulties, the physicians appointed to these posts have done an outstanding job of providing leadership to the people of their communities.

The impact of federal health programs has been felt in many ways. Implementation of Medicare and Medicaid legislation has pointed up problems in our system for the delivery of medical care. It has also shown, I think, that these problems are extremely complex and cannot be solved simply by the providing of increased funds. Accordingly, there has been increasing federal emphasis on health planning, through various channels such as the "Partnership for Health" (Comprehensive Health Planning), and the Regional Medical Programs.

In the general area of health planning, Iowa is well ahead of much of the rest of the country by virtue of the efforts of the Health Planning Council of Iowa, which was organized well before the passage of major federal legislation on the subject. The medical profession was instrumental in creating HPCI, and it has played an equally strong role in the development of the Iowa Regional Medical Program and the Comprehensive Health-Planning Council. In Iowa, though not in some other parts of the country, these three major health-planning bodies have achieved a high degree of cooperation and coordination.

A GLIMPSE OF THINGS TO COME

What of the future? I think we can look for increasing emphasis on the problems of our total health system, and increasing federal involvement in finding solutions for these problems. The prospect of such federal involvement arouses considerable apprehension in the minds of many, and admittedly it does have some potentially detrimental aspects. My own opinion is that our response should not be any direct opposition to federal participation, but rather should be a redoubling of efforts to develop strong state and local organizations, having a capability to plan and direct health programs in such a way that the federal government can be a resource rather than the controlling factor.

This strengthening of health organization in Iowa must involve both the official and voluntary sectors. We need a strengthening of the State Department of Health, and a developing and expanding of capable, functioning local health departments. Simultaneously, the statewide health-planning effort being carried on by HPCI, CHP and RMP must continue, and the development of areawide health-planning councils must be accelerated.

The Iowa Medical Society has always played a key role in developing Iowa's health programs. If we are to meet the challenges of the future, the Society's interest and involvement in public-health activities must be maintained and intensified. I am sure that this will occur, and that the solutions that Iowans achieve will be their own.

Morbidity Report for Month of November, 1969

Diseases	Nov. 1969	1969 to Date	1968 to Date	Most November Cases Reported From These Counties
Brucellosis	2	37	31	Chickasaw, Scott
Chickenpox	610	4,387	5,954	Cerro Gordo, Chickasaw, Emmet, Johnson, Lee, Muscatine, Polk
Encephalitis				
California virus	1*	4	3	Woodbury
viral	5	17	1	Benton, Bremer, Calhoun, Des Moines, Plymouth
type unspecified	4	8	7	Appanoose, Delaware, Harrison, Linn
German measles	62	2,386	1,909	Buchanan, Polk
Gonorrhea	299	3,942	3,619	Scattered
Hepatitis, infectious	22	356	448	Lee, Linn
Hepatitis, serum	1*	3	1	Adair
Histoplasmosis	3*	19	30	Clinton, Hardin, Polk
Impetigo	138	662	664	Black Hawk, Kossuth
Infectious mononucleosis	38	490	405	Black Hawk, Polk
Malaria, imported				
P. falciparum	3*	8	1	Polk
P. vivax	3*	17	8	Adair, Buena Vista, Polk
Measles	2	340	108	Polk, Sioux
Meningitis				
aseptic	2*	8	6	Benton, Franklin
Echo 3	1	1	0	Warren
meningococcal	2	21	57	Davis, Mahaska
type unspecified	10	27	23	Scattered
Meningo-encephalitis	1	6	2	Wright
Mumps	167	4,312	11,811	Black Hawk, Des Moines, Jasper, Wapello
Pneumonia	132	536	290	Johnson, Linn, Pottawattamie, Story
Rabies in animals	8	91	119	Scattered
Rheumatic fever	1*	31	25	Linn
Salmonellosis				
S. anatum	1	1	0	Polk
S. blockley	1	4	1	Polk
S. enteritidis	3	4	11	Palo Alto, Polk, Pottawattamie
S. panama	6	10	2	Hardin, Henry
S. typhimurium	6	37	38	Woodbury
Shigellosis				
S. sonnei	24	108	50	Dallas, Polk
Streptococcal infections	570	4,330	4,909	Johnson
Syphilis	63	677	666	Scattered
Tuberculosis	16	117	109	Scattered
Whooping cough	2	15	67	Des Moines, Marion

* Delayed

Pediatrics Academy Calls for Local Sports Medicine Councils

Establishment of local sports medicine councils located within school board areas has been proposed by the American Academy of Pediatrics. In a statement appearing as a supplement to the December, 1969, AAP NEWSLETTER, the Academy's Committee on Youth urges all national organizations interested in the health status of children and youth participating in sports and recreational activities, "to approve, actively support, and encourage all its membership to develop these councils in every community throughout the United States." Membership in the sports medicine council would consist of the school administrator, athletic coach, trainer, physician, and athlete.

Sports medicine councils would have these primary functions:

- To evaluate all local resources (material and individual) available for the provision of the highest quality of health care for the athlete.
- To review and implement established policies of national organizations which are recognized as leaders in health concerns for the athletic participant.
- To inspect sports equipment periodically, and call any deficiencies and substandard equipment to the attention of the appropriate authorities. These authorities shall then be empowered to cancel any athletic event until the necessary recommendations have been activated.
- To review instances where injury or illness related to sports participation has occurred, and make recommendations to eliminate recurrences.
- To provide for the dissemination of all pertinent information related to sports medicine to the public, local medical societies, school administrators, coaches, trainers, athletes, and others.
- To promote workshops, conferences, and other educational endeavors for the preparation and continuing instruction of those who are responsible for the health and safety of young athletes.

"Adverse Reaction" Information Sought From Hospitals

The editors of the AMA REGISTRY ON ADVERSE REACTIONS DUE TO OCCUPATIONAL EXPOSURES need the assistance of hospital medical staffs in collecting information on the adverse effects of new chemicals, biological or physical agents, or from exposures to old materials used in new processes.

Physicians are urged to submit reports of single observations, from which aggregate compilations may establish probabilities of cause-effect relationship. Report forms are available from the AMA Department of Occupational Health, 535 North Dearborn Street, Chicago 60610.

Woman's Auxiliary News

From the President's Desk

With the New Year just started and with the Holiday Season a recent happy memory, we hope that each Auxiliary member has resolved to do her part to make 1970 the most productive and fruitful Auxiliary year ever.

As I review the work of my predecessors and in making plans for the early months of 1970 and the Annual Meeting I have been impressed with the good works that have gone before and stimulated to expect great things in the coming months.

Specifically, I should like to emphasize the need to promote our principal project theme for the year, "Children and Youth." We are looking to the membership to promote this activity at the grass roots. Certainly no project is more important.

Of vital importance to the health and growth of our organization is the constant quest for new active members. The constant transfusion of new blood into an organization such as ours is highly desirable as a stimulating and revivifying influence on the entire group. To use the currently popular word, we can not afford to become effete. As we strive for new memberships we also earnestly solicit the reactivation of former members.

Plans for the Annual Meeting in April are developing nicely, and it is expected that it will be an event that all members will wish to participate in. Please mark your calendar for April 26-28, 1970, and plan to be with us in Des Moines.

—Jeanne Coughlan (Mrs. D. W.)

Medical Equipment Sent to Yucatan

Mrs. Max Wetrich, of Grand Junction, a member of the Greene County Medical Auxiliary, has contributed medical equipment and supplies from the office of the late Dr. Wetrich for shipment to the Partners of the Alliance program. The equipment was shipped to Iowa's Partner State of Yucatan to be used at a charity hospital in Merida, and the Xocenpich Presbyterian Mission clinic. Medicines went to these two hospitals with some also going to Presbyterian nurses who work in jungle areas of the peninsula.

WA-SAMA

What is it? The Woman's Auxiliary to the Student American Medical Association is an organization that you may have wished existed during the trying years when you were the wife of a medical student, intern, or resident. Or perhaps you *did* belong to WA-SAMA.

Founded with 27 chapters in 1957, WA-SAMA today has more than 60 chapters, one of which is at the University of Iowa.

The main goal of WA-SAMA is to assist young "medical wives" find their place in the practicing profession. Dollars and cents, or lack thereof, during student days is still a problem. For this reason WA-SAMA operates its growing programs with only token dues and with the kind support of its kind friends in the medical community.

YOU CAN HELP: Your sustaining membership in WA-SAMA will help to keep young wives in tune with the world of medicine. Their student husbands do not have time to keep them informed, so WA-SAMA is the answer.

Mrs. C. O. Adams, of Mason City, is the Iowa "WA-SAMA mama," a liaison between the Iowa City group and the Woman's Auxiliary to the Iowa Medical Society.

Please accept offer of a sustaining membership, fill in the application below, attach your check for $5.00 and mail it to the address shown. As a sustaining member, if you so indicate, you will receive CHATTERBOX to help you keep abreast of what your Auxiliary colleagues-to-be are doing to further the cause of good medicine and medical practice.

WOMAN'S AUXILIARY TO THE STUDENT
AMERICAN MEDICAL ASSOCIATION
2635 Flossmoor Road, Flossmoor, Illinois 60422

I would like to help WA-SAMA with their National Programs.

Here is my contribution of $5.00.

☐ Place my name on your mailing list for CHATTERBOX.

NAME

STREET ADDRESS

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People to People

On September 17, 1969, twenty-three Iowa doctors and their wives took off from La Guardia Field, in New York, for a three-week People to People tour of six European countries, three of them behind the Iron Curtain. Our delegation's host and hostess were Dr. and Mrs. Cecil W. Seibert, of Waterloo, and a more charming, considerate and delightful couple could not have been found anywhere for this assignment.

Our first stop was Brussels, Belgium. There, for the first time, we who had not visited Europe before were introduced to antiquity far removed from the United States. There were charming old churches and other buildings wherever we looked. The people were anxious to be helpful, were friendly, and made us feel most welcome. Some of us were fortunate enough to visit the United States Embassy and spend some time with Ambassador John Eisenhower, who is as warm and outgoing as his father was.

Our next stop was Stockholm, Sweden. We were met at the airport there by Dr. Thore Olovson, one of Sweden's physicians, who extended to us the warmest of welcomes. To me, the Swedish people were the most hospitable of all those we visited. One evening, we were each invited to a Swedish doctor's home for a typical Swedish dinner—a gourmet's delight. The food, wherever we ate in Stockholm, was great—a dieter's despair.

Then behind the Iron Curtain for three days in Leningrad and three in Moscow. Russia is a country of contrasts, of stark modern-appearing apartments by the hundreds, and ancient churches and palaces. The streets were alive with people from dawn until late at night. There was virtually no automobile traffic, but thousands of people walking, walking, walking.

The art galleries and churches (which are now museums) are beautiful. I could have spent weeks wandering from one room to another examining collections that defy description. The subway in Moscow was an experience one never forgets. It is absolutely immaculate, and contains crystal chandeliers, oil paintings, and statues wherever you look.

The people were warmly, but plainly dressed. Their faces were expressionless—a smile was a rarity.

Warsaw, Poland, was our next stop. I have no words to express my deepest admiration for these people. Out of a population of 1,300,000 before World War II, 800,000 died, either from the bombings or before firing squads. The city was demolished so that only 15 per cent of it was left standing—but with courage, toil and determination they have rebuilt, so that once again over a million people call Warsaw home.

Czechoslovakia came next on our tour. There we saw the kind of castles I had always visualized, and crossed bridges that were built before Columbus discovered America. We visited the site where the young Czechoslovakian patriot burned himself to death in protest against the Russian occupation. Surrounded by the USSR and Eastern Germany, these people live in fear of further tyranny, but one feels they have a determination to be free that will not be denied.

Our last and shortest visit was in West Berlin. As we crossed from East to West Berlin, we spontaneously clapped and cheered. After twelve days behind the Iron Curtain, even the air seemed fresher to us. The infamous wall is all that you have read and more—a hideous thing in an age when all men should be free.

Our return to the United States was without incident. We were tired and filled with thoughts of what we had seen and learned.

I am sure that I am not unique in believing that although ours may not be a perfect government, it is the best that man has devised. I, for one, am glad and proud to be an American.

—BERNIS WICKS (MRS. RALPH L.)

Meet Our Members

Mrs. Robert H. (Ellen) Kuhl was born and reared in Berwick, Pennsylvania, she graduated from Pa. State Teacher's College, Bloomsberg, Pa. and she taught for five years before marrying Dr. Robert H. Kuhl, of St. Louis, in 1941.

They moved to Creston, Iowa in 1950—where he is a surgeon associated with the Creston Medical Clinic. They have four children—two married daughters and two sons and two grandchildren.

The Kuhls had a delightful trip last May when they spent two weeks in Switzerland. Ellen particularly enjoyed it, since she is of Swiss descent.

Ellen (as she is affectionately known to her friends) is a friendly, vivacious, capable person and is active in community affairs. She was president of the 1,300-member Hospital Auxiliary in Creston for two years, and was instrumental in helping get it organized in the new 80-bed Community Hospital. The organization's many programs include a snack bar, gift shop, pink ladies, etc.

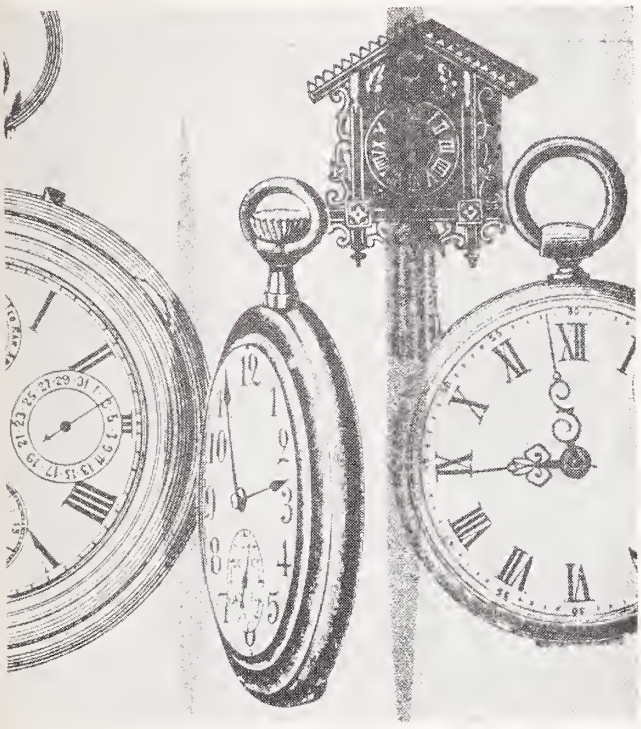
She is also a member of Women's Club, Ladies Literary Society, P.E.O., A.A.U.W., Iowa Medical Auxiliary and Presbyterian Church—a busy lady indeed!

—VI SAMPSON (MRS. CARL E.)

* * *

Mrs. W. A. Seidler, Sr., of Des Moines and formerly of Jamaica, Iowa, has been reappointed to the Governor's Commission on Children and Youth. The Commission will be working on the Iowa report to the 1970 White House Conference on Children and Youth which is to be held next December. Mrs. Seidler is a past-president of the state Auxiliary.

The Time Is NOW!



The Time is NOW . . . Mark this date on your calendar . . . Tuesday, February 10, 1970—9:30 A.M.

Plan now to attend the February Legislative Breakfast when the Auxiliary will entertain the Legislative Ladies. John H. Sunderbruch, M.D., president-elect of the Iowa Medical Society, who was a member of the Iron-Curtain People to People trip, will speak on "Medicine Behind the Iron Curtain," and will present slides taken during the medical portions of the tour.

Children Learn What They Live

If a child lives with criticism, He learns to condemn.
If a child lives with hostility, He learns to fight.
If a child lives with ridicule, He learns to be shy.
If a child lives with shame, He learns to feel guilty.
If a child lives with tolerance, He learns to be patient.
If a child lives with encouragement, He learns confidence.
If a child lives with praise, He learns to appreciate.
If a child lives with fairness, He learns justice.
If a child lives with security, He learns to have faith.
If a child lives with approval, He learns to like himself.
If a child lives with acceptance and friendship, He learns to find love in the world.

Many Facets of Mental Health

The Fall Conference in Chicago was like "Old Home Week" for some of us—but an entirely new experience for others. The inspiration and enthusiasm for Auxiliary work displayed at those meetings is really contagious. I wish all physicians' wives could—and would—have been there!

Again this year special emphasis is being placed on "Accent on Youth," "broadening it, whenever possible, to include a strengthening of the family unit," as Mrs. John M. Chenault suggested in her inaugural address.

We are beginning to realize that mental health is the sum total of the quality of a man's environment, the quality of his life and the way he lives it. This, of course, includes a man's life at work. The problem of mental illness in the United States is BIG. On the basis of size alone, it must concern us all. The goal of the national mental-health program will have been achieved when we have learned to prevent mental illness, to promote mental health and to provide a continuity of care for people who are already emotionally disturbed or mentally ill. Determine the needs of your community, arouse the interest of your membership, and then work with the mentally healthy, helping to keep them well. The many facets of Mental Health provide all of us the joy of working with people and an opportunity to serve.

Mrs. Chenault stated it so aptly: "What I should like to do is get the individual member of the individual county Auxiliary to open her eyes and look around and see what needs to be done. And then we want her to go to the county Auxiliary and get something going. . . . One of the greatest things the Woman's Auxiliary can do is to educate the people as to what is available in a local community in the field of health."

Let's get going on:

1. Panel discussions, debates, speakers
2. Presentations of community resources available
3. Film showings
4. Programs based on package programs, books, pamphlets, articles
5. Recordings (we have records of the radio program series "Mirror to the Mind")
6. Play presentations
7. Placing Drug Abuse posters in prominent places
8. Volunteer work in centers and raising money for them.

Are you interested in having a list of materials and films available on:

1. Alcoholism
2. Children (Detection of problems)
3. Mental Health Careers
4. Drugs
5. Facts About Mental Illness
6. Sex Education

7. Suicide and
8. Worry-Ins?

Many pamphlets, bulletins, booklets and film titles are available from the AMA, the National Institute of Mental Health, HEW and the Public Health Services. Need some?

Your State Health Chairman, Mrs. M. D. Hayden, has received these suggestions and the list of available materials.

—LENOR BISHOP (MRS. JAMES F.)
North Central Regional Mental Health Chairman

11. Legislation Information Capsule

SF 91—CHIROPRACTIC

Q. What is the present status of the bill?

A. Senate File 91 was debated on the floor of the State Senate in 1969, amended several times, and referred back to committee. It may again come before the Senate during the 1970 session, and if passed, go to the House for consideration.

Q. What is the purpose of the bill?

A. To expand the scope of chiropractic. It would no doubt allow chiropractors to use laboratory diagnostic tests and even enable them to do insurance physicals, etc.

Q. How would the bill change the present law?

A. As it is worded, no one is sure. The scope of chiropractic is now quite well defined, and the vague wording in the new law would take many years after enactment to define through courts exactly what chiropractors could legally do.

Q. What is the stand of IMS on this bill?

A. It opposes change in the present legislation. Those chiropractic interests behind the legislation still have not demonstrated a need for a change in the present law, nor made it clear what actual changes they are seeking. Vague wording tends to arouse suspicions, and amendments attempting to clarify terms were opposed by chiropractic forces in the 1969 session.

Q. Is this bill opposed by any other health-related groups?

A. The Iowa Chapter of the Arthritis Foundation published a statement of opposition to the bill as "not in the best interests of the more than 380,000 Iowans afflicted with some form of rheumatic disease," and urged citizens to voice their opposition to their senators and representatives. The Arthritis Foundation opposes broadening the scope of chiropractic because "current license and practice definitions of chiropractic in Iowa are clear and concise, and exist for the protection of both the arthritic and the general public." Many other groups have expressed opposition.

Q. Why are chiropractors lobbying so hard for this bill?

A. Not all of them are. They are divided among themselves, but those who seek the change have made a strong lobbying effort. Perhaps their reasons are varied, but with the general public's increasing faith in, and understanding of, research, chiropractors may well believe they are fighting for their very existence.

Q. Why doesn't the IMS just ignore this bill and let it pass?

A. It is true that physicians have nothing personally to gain from its defeat, for passage would not create severe competition for them even though the scope of chiropractic were greatly enlarged. Physicians' interest is simply in protecting Iowans from having practitioners exceeding the bounds of those things they are adequately trained to do.

Around the Hawkeye State

Black Hawk County

The Black Hawk County Medical Auxiliary is off to a promising start for the new year. The October meeting was a dinner at the home of Mrs. Vernon Plager, Waterloo. Gifts and game prizes for the patients at the County Health Center were brought. The program was an illustrated talk by Mrs. Gardner Phelps, of Waterloo, on "A Trip to Puerto Rico." Dr. and Mrs. Phelps spent four weeks doing volunteer ophthalmological work in a mission hospital there. It was the fifth such trip they have made to the Latin American countries.

The November meeting was a luncheon in the home of Mrs. David Hansen, Cedar Falls. Mrs. John Kestel, of Waterloo, gave a demonstration of holiday flower decorations.

Among the Black Hawk Auxiliary's service projects are numbered several purchases—a 16 mm sound projector, a 35 mm slide projector, and several small radios—for the Black Hawk County Health Center.

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. D. W. Coughlan, 1435 Park Avenue, Des Moines 50315
President-Elect—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501
Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312
Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228
Editor of THE NEWS—Mrs. D. A. Mater, 302 S. 4th Street, Knoxville 50138
Assistant Editor—Mrs. R. J. Foley, 1025-16th Street, West Des Moines 50265



Personals



Dr. John W. Eckstein, a professor of internal medicine at the U. of I., has been named vice-president of the Great Plains Region of the American Heart Association, which includes Kansas, Missouri, Minnesota, Nebraska, and North and South Dakota, in addition to Iowa.

A 12-bed comprehensive burn-treatment facility, which can be expanded to accommodate as many as 15 patients if necessary, has been opened at University Hospitals, Iowa City. Some 40 to 50 patients with severe burns requiring extended periods of treatment are admitted at University Hospitals each year, and the new unit occupies a ward area on the fifth floor that formerly was divided into four separate rooms. According to **Dr. Sidney E. Ziffren,** acting head of the Department of Surgery, the new unit was designed to take advantage of the latest techniques in burn treatment.

Dr. Howard B. Latourette, a professor of radiology at the U. of I. College of Medicine, was elected president of the American Cancer Society, Iowa Division, Inc., at the organization's annual meeting in Des Moines on November 21. **Dr. Richard A. Hastings,** an Ottumwa radiologist, was named chairman of the board, and **Dr. Addison W. Brown,** a Des Moines obstetrician and gynecologist, was made a lifetime honorary member.

Dr. Ronald R. Roth, a 1964 medical graduate of Creighton University, has joined **Dr. Eugene Smith** in general practice in Waterloo. He interned in Phoenix, and subsequently practiced for two years in Miami, Arizona. During one of his two years in Army uniform, he received an award for developing a method for screening inductees with medical conditions requiring their separation from service, and he also helped to develop a tuberculosis-screening program. During the other one of his years of military service, he was stationed in Vietnam. He and Mrs. Roth have two children.

Dr. E. K. Vaubel, of Estherville, was one of the speakers at the November 12 meeting of the Iowa Lakes Licensed Practical Nurses Association, held at Holy Family Hospital there. Twenty-three nurses were present.

At the fall meeting of the Iowa Dietetic Association, in Des Moines on November 12, **Dr. Richard Lawton,** director of the renal dialysis center at the Iowa City VA Hospital, spoke on "Current Aspects of the Artificial Kidney as an Organ Support System for the Transplant."

Dr. William deGravelles, head of physical medicine at Younker Memorial Rehabilitation Center, Des Moines, has been named chairman of the Iowa State Stroke Advisory Committee.

At a meeting of the Gateway Personnel Association on November 11, **Dr. W. R. Meyer,** president of the Clinton County Medical Association called for improved communications between hospitals, on the one hand, and industry, police and fire departments, and ambulance services, on the other, in case of disaster. As an example of failures that can take place, he cited an instance during construction of the Commonwealth Edison Co. plant when hospitals were alerted to prepare for ambulance loads of patients which, as far as the Clinton hospitals were concerned, never materialized. After a two-hour wait, it was learned that injured workmen had all been taken to Moline, Illinois, hospitals.

Members of the Iowa Chapter of the American Academy of General Practice conducted one of a series of four programs, November 13 at the Ramada Inn, Iowa City, designed to interest U. of I. medical students in becoming Iowa family physicians. It was a panel discussion in which the participants were **Drs. C. E. Douglas,** of Belle Plaine, **Dr. H. R. Light,** of Grinnell, and **Dr. D. J.**

Walter, of Des Moines. The other three meetings, for all of the medical students and their wives, were planned for December, February and April.

Dr. Alexander Ervanian, a Des Moines pathologist, has arranged to work each Monday at the Cass County Memorial Hospital, in Atlantic.

The Iowa Heart Association and the State Department of Social Services are cosponsoring a series of six two-day workshops on "Medical Problems of the Aged and the Handicapped" for social workers. At the one held in Independence early in November, one of the speakers was **Dr. Paul From**, a Des Moines cardiologist and chairman of the Capitol Stroke Project.

A Des Moines obstetrician and gynecologist, **Dr. Don O. Newland**, was elected president of the University of Iowa Dads' Association at the organization's meeting in Iowa City during November. It was organized in 1955, and meets each year during Dads' Day Weekend.

Dr. Lewis E. January, a professor of internal medicine at the U. of I., received the American Heart Association's Gold Heart Award, in Dallas on November 16. It was given, this year, to three men—two of them physicians—for their work in advancing AHA programs and objectives.

Dr. Mary Lou (Aukes) Khowassah, a 1968 graduate of the U. of I. College of Medicine who completed her internship at University Hospitals, Iowa City, in July, is practicing general medicine with **Dr. Harold Moessner** in Amana. Her home town was Buffalo Center, and she took her undergraduate college work at Luther College, Decorah.

Dr. Craig Ellyson, a Waterloo general practitioner, and **Dr. A. S. Norris**, a professor of psychiatry at the U. of I., participated with a state senator, a priest and two high school teachers in a panel discussion of sex education in the medical amphitheater of University Hospitals on November 20. The local chapter of the American Student Medical Association was the sponsor.

Dr. John L. Parks is the newly-elected president of the Muscatine County Medical Society. **Dr. Samuel Bluhm** is vice-president, and **Dr. Keith Wilcox** is secretary-treasurer. All of them practice in Muscatine.

During the World Mental Health Assembly, in Washington, D. C., November 17-21, **Dr. Harry D. Harper, Jr.**, a Fort Madison psychiatrist, reported on introducing a family-planning program in a state mental hospital in Iowa.

Among the speakers at the semi-annual meeting of the Iowa Tuberculosis and Respiratory Disease Association, at Johnny and Kay's Hyatt House, Des Moines, November 13, were **Dr. Sergio Rabinovich**, an associate professor, and **Dr. Ian Maclean Smith**, a professor, both in the Department of Internal Medicine at the U. of I., and **Dr. Elizabeth Procter**, of the State Department of Health, Des Moines.

During the early morning of Sunday, November 9, the offices of **Drs. Robert Donlin, Wm. S. Markham** and **R. D. Harris**, in Harlan, were broken into. Some cash and some codeine tablets were taken.

Dr. David Gordon, a Des Moines cardiologist, conducted a cardiopulmonary resuscitation program for the nurses of central and southwestern Iowa, on November 20, at the nurses' residence at Mercy Hospital, Des Moines.

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At the November 4 meeting of the Wapello County Medical Society, held in the Ottumwa Country Club, **Dr. Don W. Chapman,** a former Iowan and now clinical professor of internal medicine at Baylor, in Houston, discussed "Diagnosis and Surgery in Coronary Artery Disease."

In preparation for the opening of an intensive care unit for coronary patients at the Dickinson County Memorial Hospital, **Drs. R. J. Coble** of Lake Park and **M. W. Kirklin,** of Spirit Lake, have been conducting a training program for the nurses who will staff it.

At the annual election held on November 4, **Dr. David H. Winter** was chosen as president of the medical staff at Marshalltown Area Community Hospital—the recently merged Mercy and Evangelical Hospitals. **Dr. Philip R. McFadden** was named vice-president, and **Dr. Russell R. Widner** secretary-treasurer. They are a general practitioner, an obstetrician and gynecologist and an ophthalmologist, respectively. Though many people consider acronyms far too numerous, the opportunity to call their two hospital buildings "MACH West" and "MACH East" was too tempting for the citizens of Marshalltown to resist.

Dr. K. A. Garber and **Dr. T. W. Davis** moved into their new office building in Corydon on October 24.

Dr. W. M. Krigsten, a Sioux City orthopedist, and **Dr. Kenneth E. Lister,** an Ottumwa surgeon, the president and the chairman of the Board of Trustees of the IMS, were the principal speakers at the December 10 Polk County Medical Society meeting, held at the Hotel Fort Des Moines. Their topic was the financing of health care, including the functions of third parties, the Medicare and Medicaid programs, the usual and customary fee concept, and peer review.

Dr. Allen Q. Tuggle has recently been employed as physician at the Des Moines Health Center. After taking his M.D. at the University of Arkansas School of Medicine in 1968, he interned at Mercy Hospital, Des Moines.

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Dr. Herbert A. Weil, who has been the physician in charge at the Armed Forces Examining and Entrance Station at Fort Des Moines and an emergency room physician at Broadlawns-Polk County Hospital, has entered private general practice with **Dr. Emerson K. Wirtz** at 1226 Grand Avenue, West Des Moines. Dr. Weil has a bachelor of science degree (major in chemistry) from the University of Pittsburgh, and an M.D. (1967) from Georgetown University. He interned at Albany Medical College. **Dr. Raymond N. Sweeney**, with a B.A. from St. Louis University and an M.D. (1968) from the University of Illinois College of Medicine, has succeeded him at the Fort Des Moines induction station. Dr. Sweeney interned at St. Mary's Hospital, San Francisco.

Dr. Eugene McCaffrey, a retired Des Moines general practitioner and the author of some reminiscences that appeared under the heading "Medical History" in the September, 1969, issue of this JOURNAL, recently received an eightieth-birthday congratulatory message from **President Richard M. Nixon.**

The Mental Health Institute at Independence held its fifth seminar entitled "Psychiatry for General Practitioners" on December 4. The guest speaker, **Wilfred Dorfman, M.D., F.A.C.P.**, director of clinical research at Brunswick Hospital Center, Amityville, New York, and the editor of PSYCHOSOMATICS, discussed "Office Management of Depression." A panel consisting of **Drs. Richard J. Moore** and **Bruce Ambler,** both psychiatrists on the Institute's staff, and **Dr. John L. Mochal,** a general practitioner at Independence, discussed "The Use and Abuse of Tranquilizers."

Dr. Sidney S. Kripke, an assistant professor of pediatrics at the U. of I. College of Medicine, discussed the measles vaccine programs at a meeting of the Johnson County Democratic Women's Club, held at the home of **Dr. and Mrs. J. A. Buckwalter,** in Iowa City on November 26.

One of the magazine sections of the DES MOINES SUNDAY REGISTER for November 30 contained a feature story about **Dr. Ralph C. Carpenter,** a Marshalltown otolaryngologist, and his interest in cookbooks. The account is frankly humorous and perhaps was not intended to be altogether factual, but it conveys the impression that his interests in the volumes is more bibliophilic than culinary. Besides accumulating cookbooks, and clipping recipes from newspapers and magazines, and pasting them into annual volumes of "Carpie's Cook-

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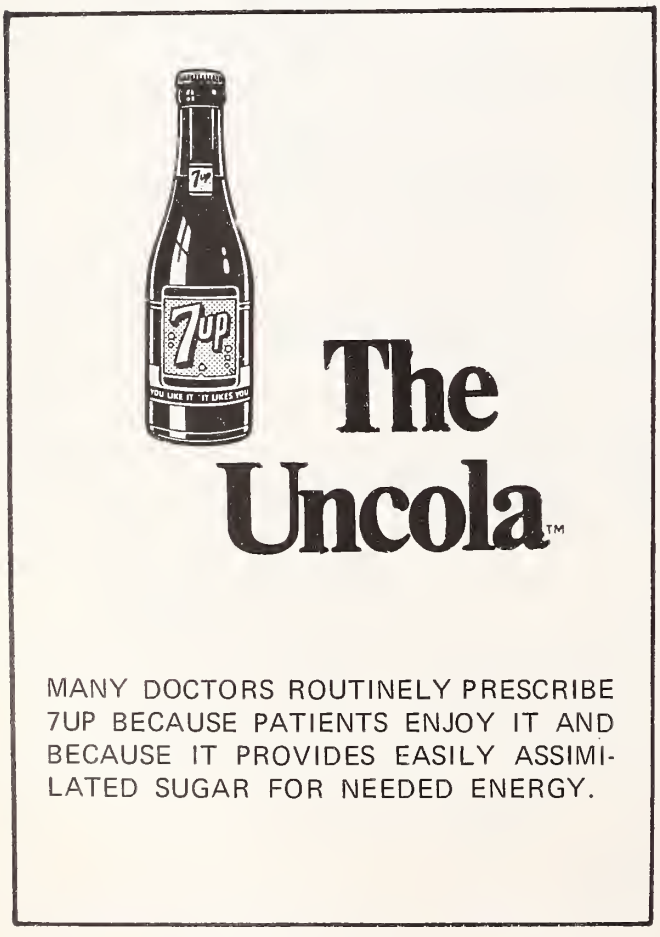
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book" (the unbroken series of which began in 1939), he has indexed and cross-indexed his collection. Mrs. Carpenter is quoted as saying that his card catalog baffles her completely: "If I wanted a recipe for some muffins I'd have to look under 'luncheon,' 'bran,' 'breakfast,' 'cornmeal' and 'bread.'" Yet, the reporter asserts, "Dr. Carpenter, a methodical man, knows exactly how to find what he is looking for, and to prove it he instantly found for us directions on how to roast a musk ox. He has never roasted a musk ox. He doesn't do much cooking from any of his recipes."

Drs. John Castell and **Kirk Strong,** of Fairfield, told about and showed slides of their recent trip through Belgium and several countries in eastern and northern Europe at a meeting of the Fairfield Business and Professional Women's Club, November 24. Their audience numbered about 80.

Dr. Paul Huston, head of psychiatry at the U. of I., and **Dr. Oscar Alden,** a Red Oak general practitioner, are two of 14 new members recently appointed to the Iowa Regional Advisory Group, which serves the Iowa Regional Medical Program (Heart Disease, Cancer and Stroke). Dr. Huston is to represent the Iowa Mental Health Authority, and Dr. Alden will represent the IMS Executive Council. The 14 additions bring the membership of the Group to 74. **Dr. Terry Dynes,** a Decorah general practitioner, was named an alternate to **Dr. John H. Sunderbruch,** of Davenport, another of the IMS representatives.



Dr. Joseph P. Trotzig moved to his newly completed office building in Akron on November 17.

Dr. Harold Rankin, a general practitioner at Mt. Pleasant, and **Kay Geary, R.N.,** director of nursing at Henry County Memorial Hospital, there, have conducted several class sessions on extracorporeal dialysis for 14 student nurses and eight nursing instructors from the Burlington Hospital School of Nursing.

Dr. A. E. Hale, who has practiced general medicine in Mason City since 1931, retired on January 1. He and Mrs. Hale intend to live in Palm Beach, Florida, and they have bought an apartment in a condominium building there. Dr. Hale took his pre-medical and medical degrees at Creighton University, interned at a hospital in Buffalo, New York, and practiced for two years in Buffalo before returning to the Midwest. He practiced for 10 years at Dougherty, Iowa, and moved to Mason City in 1941. During World War II he served almost three years as a captain in the Army Medical Corps. The Hales have two daughters—**Mrs. H. A. Porter,** who teaches in Mason City, and **Mrs. Joseph Worden,** of Manchester, Iowa—and a son, **James,** who is a doctoral candidate at the University of Iowa.

Dr. E. B. Grossmann, Jr., rejoined his father in practice at Orange City, November 24. The younger Dr. Grossmann worked there briefly, following his internship, in the summer of 1963 while waiting to be called to duty in the Air Force. After two years at Castle AFB, Merced, California, he served a surgical residency at Iowa Methodist Hospital, Des Moines, and he is now a board-qualified general surgeon and a candidate member of the American College of Surgeons. He and his wife have three sons, six, four and 1½ years of age.

Dr. William E. Bell, an associate professor of pediatrics at the U. of I. College of Medicine, addressed the Wapello County Medical Society, December 2, on "Diagnosis and Management of Nervous System Infections in Childhood." The meeting was held at the Ottumwa Country Club.

Dr. Robert O. Bailey, of Waterloo, was given a special service award at the annual meeting of United Cerebral Palsy of Northeast Iowa, December 1, at the Elks Club there. **Dr. Don H.**

Penly, of Cedar Falls, is to succeed Dr. Bailey as the Black Hawk County Medical Society's liaison with the cerebral palsy association.

Dr. Harry Harper, Jr., a psychiatrist, and **Dr. Jaime Polit,** an internist, were two of six panelists at a drug abuse symposium presented in the Fort Madison Junior High School auditorium on December 2.

John R. Porter, Ph.D., head of microbiology at the U. of I. College of Medicine, is vice-president of the International Conference on Global Impacts of Applied Microbiology, which held its third meeting December 7-12 in Bombay, India. Discussions centered on topics in agricultural, medical, veterinarial, and food and water microbiology, especially in developing nations.

Dr. Elmer M. Smith, director of the Bureau of Medical Services in the State Department of Social Services, has been appointed to the 21-member National Medical Assistance Advisory Council. The group is concerned particularly with the Medicaid program.

On November 18 the Wright County Medical Society had an opportunity to hear talks from the County's two state legislators, **Representative Lucy Duitscher** and **Senator Hugh Clark.** They discussed many issues frankly with physicians in the audience and provided them a great deal of information which they, as citizens, needed.

Dr. Robert T. Soper, a professor of surgery at the University of Iowa, was one of four M.D.'s whose views on the repair of hernia in infants on an outpateint basis appeared in the December 1 issue of MODERN MEDICINE. He said, in part, "I heartily endorse the principle of outpatient elective herniorrhaphies in infants. . . . The basis for this is a . . . happy experience with . . . children up to six or seven years of age at the University of Iowa Hospitals during the past eight years. . . . The child must be small enough to be carried to and from the car with ease." Dr. Soper also outlined his operative technique in some detail. Two of the other three authors agreed with him.

Dr. Richard M. Caplan, a professor of dermatology and director of medical education at the U. of I., spoke on "Opportunistic Fungal Disease" and served as chairman of a symposium on educational methods at the annual meeting of the American Academy of Dermatology, in Miami Beach on December 6-11. On December 5 he had

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participated in committee meetings of the group which is formulating a national master plan for education, service and research in dermatology.

Dr. Dan Kelly, a 1968 graduate of the Creighton University Medical School who interned at Brackenridge Hospital, Austin, Texas, has been practicing for several months with **Drs. C. C. Moore** and **L. E. O'Connor.**

Dr. Willard A. Krehl, currently a professor of internal medicine and director of the Iowa Regional Medical Program, is about to move to Philadelphia. Effective February 1, 1970, he is to join the staff of the Department of Preventive Medicine at Jefferson Medical College.

Dr. Edward Farrage is the newly installed president of the medical staff at Mercy Hospital, Council Bluffs, succeeding **Dr. Ralph Hopp. Dr. Kenneth E. Goebel** was made president-elect, and **Dr. Lucy M. Radicia,** secretary-treasurer.

Dr. Don Orelup, of Albia, was the subject of a feature story in one of the magazine sections of the DES MOINES SUNDAY REGISTER, December 14. It was entitled "Busy Days (and Nights) of an Albia Doctor."

Early in December, **Dr. Glenn Skallerup,** of Red Oak, was a principal speaker at a meeting on the use and abuse of depressant and stimulant drugs at the junior high school auditorium there. The audience is said to have numbered about 500.

On December 11, the Fayette County Medical Society chose **Dr. Larry H. Boeke,** of West Union, as its president. **Dr. W. J. Wolf,** of West Union, was named vice-president, and **Dr. John Gallager,** of Oelwein, secretary-treasurer.

Deaths

Dr. Edward J. Liska, 69, a physician, town councilman and former mayor at Ute, died in Rochester, Minnesota, on November 21, after a long illness.

Dr. Amandus H. Grau, 64, a 1930 graduate of the U. of I. College of Medicine, died at the Crawford County Hospital, in Denison, on November 15, following a long illness. His home had been in Denison since he was 10 years old, and he had practiced medicine and surgery there for about 35 years.

Dr. John F. Kelly, 53, a Sioux City general surgeon, died at his home on Sunday afternoon, November 23. He was a 1940 graduate of the U. of I. College of Medicine, he interned and served his residency at Harper Hospital, Detroit. He served as a first lieutenant in the Army Medical Corps. He had practiced for 24 years.

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- Interrupting the Family Cycle of Violence—Richard L. Jenkins, M.D., Robert Gants, M.A., Takeshi Shoji, M.A., and Edna Fine, M.S.W.
- The Three-Century History of an Iowa Family With Huntington's Chorea—Richard Finn, M.D.
- Idiopathic Thrombocytopenic Purpura in Childhood—James C. Taylor, M.D.
- The Use and Misuse of Psychotropic Drugs: A Panel Discussion



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Vol. LX FEBRUARY, 1970 No. 2

CONTENTS

SCIENTIFIC ARTICLES

Interrupting the Family Cycle of Violence
Richard L. Jenkins, M.D., Robert Gants, M.A., Takeshi Shoji, M.A., and Edna Fine, M.S.W. 85

The Three-Century History of an Iowa Family With Huntington's Chorea
Richard Finn, M.D. 89

Idiopathic Thrombocytopenic Purpura in Childhood: An Approach to Therapy
James C. Taylor, M.D. 94

The Use and Misuse of Psychotropic Drugs: A Panel Discussion 98

EDITORIALS

Diverticulosis and Diverticulitis of the Colon . . 107

Trends in the Use of Forceps 108

Arterial Hypertension: Diagnosis and Treatment 110

SPECIAL DEPARTMENTS

The Month in Washington 78

Coming Meetings 82

President's Page 106

University Hospitals Drug Letter: "Pentazocine"—Roger K. Ferguson, M.D. 112

Information from the Iowa Heart Association: "Recognition of Pulmonary Embolism"—James K. Alexander, M.D. 114

State Department of Health 116

Iowa Association of Medical Assistants 120

The Doctor's Business 121

Woman's Auxiliary News 123

Personals 129

Deaths 138

In the Public Interest facing page 142

MISCELLANEOUS

Prescribing of Drugs in Thirty-Day Supplies: A Blue Cross-Blue Shield Informational Letter to Physicians 115

AMA Judicial Council Frowns on Physicians' Treating Close Relatives 118

Movie Designed to Recruit "Volunteer Physicians for Vietnam" 118

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.....Des Moines

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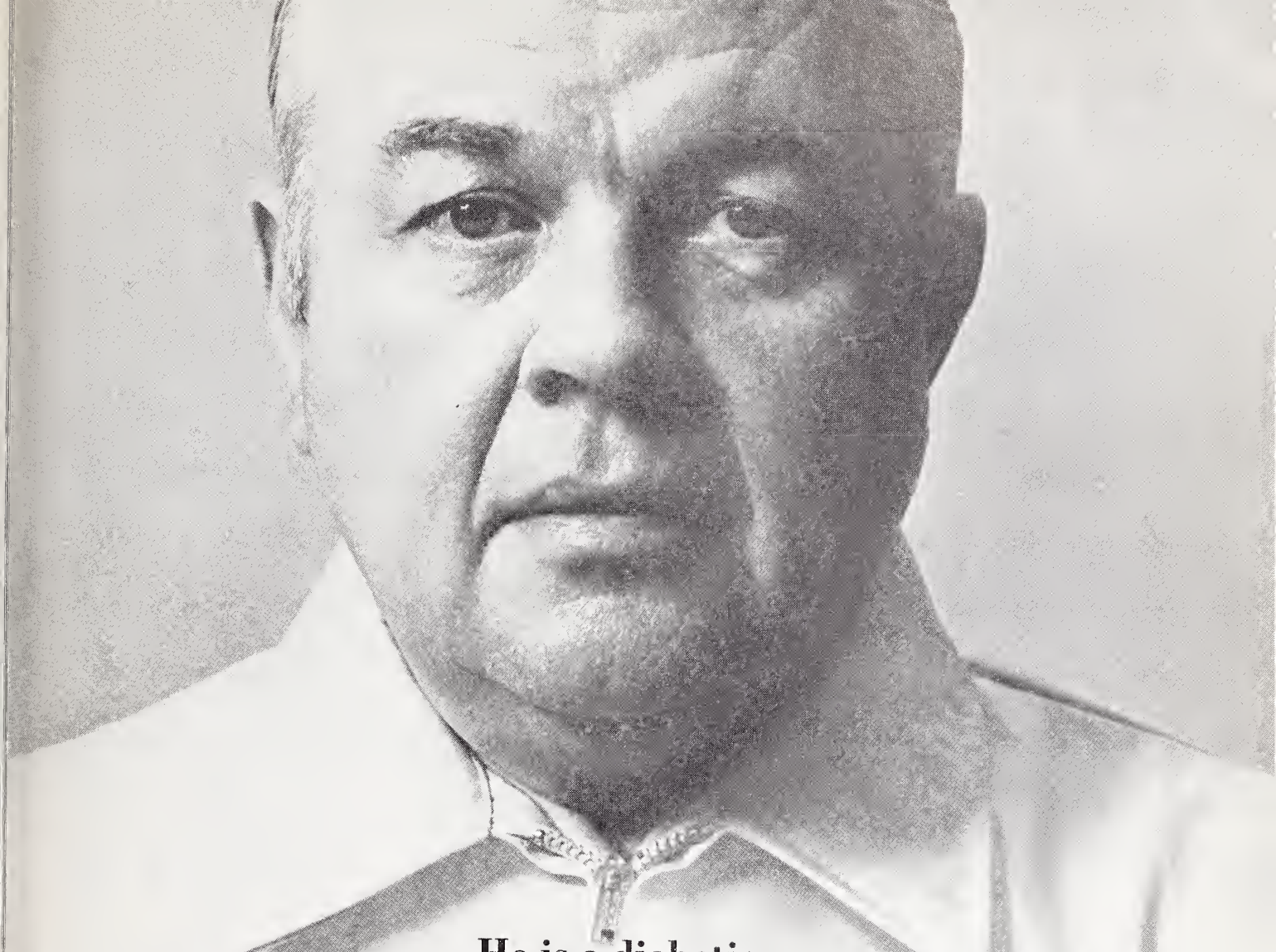
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

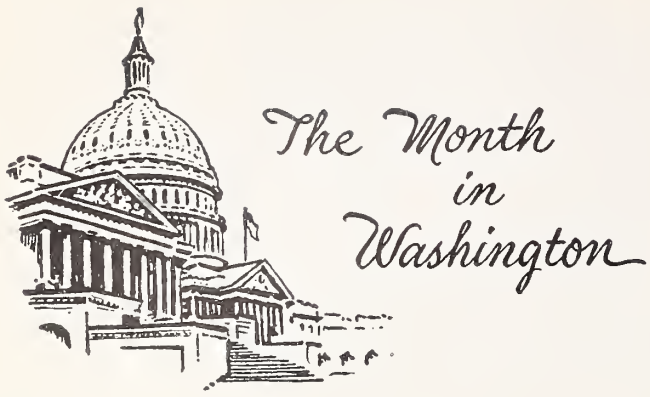
Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Washington—The Internal Revenue Service postponed until next Jan. 1 one provision of a new requirement that health insurance companies report to the IRS payments of $600 or more a year to a physician.

The delayed provision covers payments other than under Medicare and Medicaid. Payments of $600 or more under these government programs must be reported to the IRS. A spokesman said that the reporting of payments other than those made under the government programs was delayed for a year to allow further time for working out compliance procedures.

The IRS regulation applies only to direct payments to physicians. The Senate added an amendment to an omnibus tax bill that would have extended the requirement to indirect payments also, but House-Senate conferees took out the amendment.

Another provision unfavorable to physicians was knocked out of the tax bill, but a third was retained.

The Senate rejected a proposal that would have restricted the tax advantages gained by physicians by organizing professional corporations under state laws for the purpose of establishing retirement plans. The Senate Finance Committee had added an amendment that would have set an annual limit of $2,500 per individual—the same as specified under the so-called Keogh law. But the Senate, by a vote of 65-25, knocked out the amendment, leaving physicians, lawyers, engineers and other members of professional corporations able to set aside as much of their income for retirement as they choose.

As finally passed by Congress, the measure includes a provision putting congressional approval on an IRS ruling that advertising revenue of medical and other non-profit, tax-exempt organizations is subject to the regular corporate income tax. Journals of state medical societies, as well as the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, are affected.

* * *

Medicare's Part B premium partially covering physicians' fees will go up for $4 to $5.30 a month next July 1.

Health, Education and Welfare Secretary Robert H. Finch blamed his predecessor in the post, Wilbur J. Cohen, for the size of the increase (32 per cent) in the premium.

Finch noted that the present $4 premium rate, set in December, 1968, was too low to cover costs during the current premium period, and that the special Medical Insurance Trust Fund has been drawing on its reserves. He said that failure to follow the advice of the Social Security Administration actuaries to increase the premium rate last December had made it necessary now, in effect, to promulgate two increases at once. Moreover, the depletion of the trust fund that has occurred because of the rate inadequacy had made it necessary, he said, to provide for a somewhat higher margin for contingencies than would otherwise have been necessary.

About half the increase, 64 cents, was needed to finance the program at the level of current operations. The other 66 cents of the $1.30 increase will be distributed thus:

—26 cents to cover an estimated increase of about 6 per cent in physicians' fees;

—about 12 cents to cover an estimated 2 per cent growth in the utilization of services under the program;

—about 6 cents because the $50 deductible which a patient pays will be a smaller proportion of the total covered charges;

—the remaining 22 cents to provide a 4 per cent margin for contingencies.

* * *

President Nixon signed into law legislation setting tough federal safety standards for coal mines.

Although he had reservations about a conflict with state workmen's compensation laws, President Nixon said "The health and safety provisions of this act represent a historic advance in industrial practices." He also cautioned that this law should in no way be considered a precedent for future federal administration of workmen's compensation programs.

For the first time, the Secretary of Health, Education and Welfare was given authority to set health standards for mines. President Nixon said he had asked that wherever possible the disability standards under the new act be consistent with those of the Social Security disability program. Pressure for the legislation started building up after 78 died in a Mannington, W. Va., mine disaster last November.

The AMA supported an overall Administration bill on occupational health and safety, and pledged the backing of the nation's physicians for any program "well designed to improve the safety and health of the American worker." Dr. R. Lomax Wells, Silver Spring, Maryland, immediate past-chairman of the AMA's Council on Occupational Health, told a Senate labor subcommittee: ". . . The American Medical Association supports the



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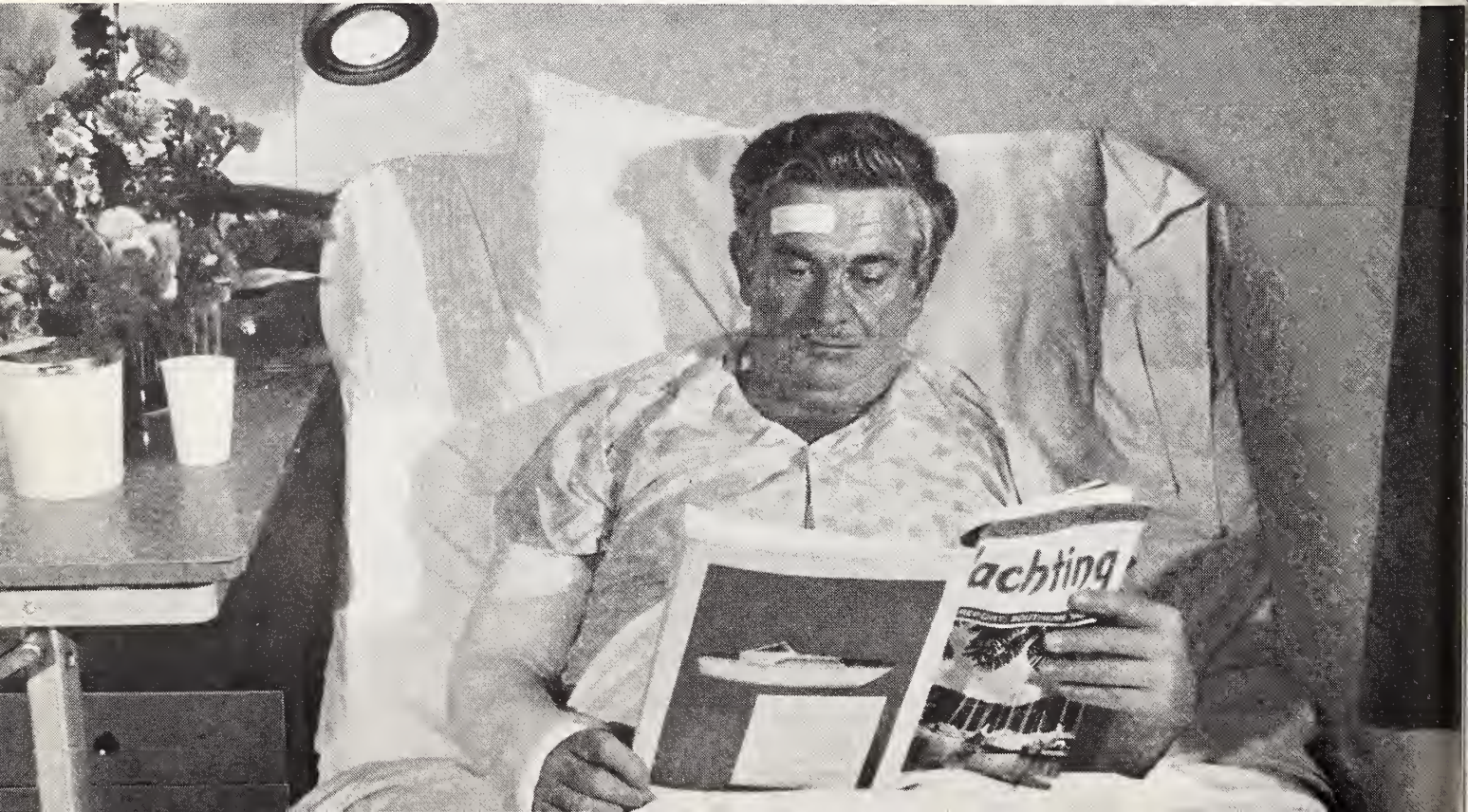
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new Administration bill, S. 2788. Its provisions for standard-setting, not in the Labor Department but in a new National Occupational Safety and Health Board appointed by the President, with a majority of professional experts, seems to us an acceptable equivalent to our previous suggestion of a National Council on Hazardous Physical and Chemical Agents. We endorse its concept of a separation of powers between standard-setting and enforcement. We welcome, in this new bill the intent to give a larger role to the Department of Health, Education and Welfare, whose competence in this field is recognized. Our Association approves the provision for federal support of state occupational safety and health programs to supplement inadequate manpower in the federal system. We believe that this emphasis on support of the state programs, combined with standard-setting by an independent professional board, is greatly preferable to mandatory national standards promulgated and enforced by a single federal agency. In this regard, we welcome the stress on the use of consensus standards, and provisions for consultation with professional standard-setting agencies before establishing needed new standards."

* * *

A National Heart and Lung Institute task force predicted that the demand for heart transplants will increase beyond the present level of about 100 a year, and will exceed the number of the organs available for such operations.

The report of the task force on cardiac replacement also said:

—Fewer than 16 per cent of the 200,000 Americans under 65 who die each year from heart disease are good candidates for transplants.

—Rejection of the transplanted heart will remain "the greatest barrier to prolonged survival."

—Development of an artificial heart is now a distinct possibility.

—The federal government should emphasize research on the prevention, early detection and early treatment of heart disease.

—A new definition of death is needed.

—Total transplant charges for 36 patients have averaged $18,694 per patient.

—Heart transplants have been performed on 148 patients, of whom 23 persons still survive, 16 of them in the United States.

—More than 32,000 heart-disease victims can be considered transplant candidates, but there are only about 22,000 possible donors a year, the report said.

* * *

The Food and Drug Administration was reorganized and given independent status under a new commissioner. The reorganization followed several years of criticism of the Health, Education and Welfare Department agency from all sides—Congress, industry and consumers' groups. The criticism resulted in a two-month study by a task force headed by HEW Deputy Assistant Secretary for Welfare Fred Malek.

The reorganization focused on FDA's structural problems, and the chief aim of HEW Secretary Robert H. Finch appeared to be to get the agency operating more efficiently. FDA was taken out of the Consumer Protection and Evironmental Health Service and placed in the Department's staff structure on an equal basis with the remaining Environmental Health Service and the National Institutes of Health.

Charles C. Edwards, M.D., 46, formerly a division director on the American Medical Association headquarters staff,* was named to replace Dr. Herbert L. Ley, Jr., as head of the FDA. Dr. Ley was offered another post in HEW, but declined it. Two of Dr. Ley's top aides, FDA Deputy Commissioner Winton B. Rankin and Associate Commissioner for Compliance J. Kenneth Kirk, were transferred from the agency.

Dr. Edwards was praised by a former associate on the AMA staff, Mr. C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, as being highly qualified by his scientific and administrative background.

The new FDA head said he would bring "hard-nosed management principles" to the agency and work more closely with industry, but that his administration of FDA would be oriented to the consumer. He said his decisions as a government official would not be influenced by his former association with the AMA.

* Still earlier, Dr. Edwards practiced surgery in Des Moines, from March, 1957, to September, 1961.

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

A most worthwhile mechanism for creating a memorial to a relative, associate, colleague or friend exists in the Scanlon Medical Foundation/Iowa Medical Society. The Foundation utilizes memorial gifts to carry forward its loan program which has helped more than 300 young Iowans finance their medical educations. The Foundation will be glad to send an appropriate card in the name of the donor to the family of the person honored. The tax-deductible memorial gifts should be directed to the Scanlon Medical Foundation/ Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

COMING MEETINGS

IN STATE

Feb. 10-13 — **Refresher Course for General Practitioners,** University of Iowa College of Medicine, Iowa City.

CONTINENTAL U. S.

Feb. 2-4 — **Sectional Meeting of American College of Surgeons,** Portland Hotel, Portland, Oregon.

Feb. 2-6 — **Postgraduate Course on High Risk Infant Care (Limitcd) sponsored by University of Colorado School of Medicine,** Denver.

Feb. 2-27 — **Postgraduate Course on Nuclear Medical Technology sponsored by Special Training Division of Oak Ridge Associated Universities,** Oak Ridge, Tennessee.

Feb. 2-27 — **Postgraduate Course on Medical Radioisotopes sponsored by Special Training Division of Oak Ridge,** Tennessee.

Feb. 4-5 — **Postgraduate Course on General Practice,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.

Feb. 8-9 — **Annual Congress on Medical Education,** Palmer House, Chicago.

Feb. 8-10 — **American Soeiety for Aesthetic Plastic Surgery,** Marriott Motor Hotel, Atlanta.

Feb. 9-10 — **Postgraduate Course on Cardiac Auscultation,** Kansas University Medical Center, Kansas City, Kansas.

Feb. 9-11 — **Postgraduate Course on Cardiopulmonary Resuscitation (for doctors, nurses and dentists) sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Feb. 12-14 — **Southwestern Medical Association,** Sheraton Motor Inn, El Paso.

Feb. 12-14 — **Second National Conference and Exposition on Electronics in Medicine,** Fairmont Hotel, San Francisco.

Feb. 14-15 — **26th Annual Meeting, American Academy of Allergy,** Jung Hotel, New Orleans.

Feb. 16 — **Workshop on Diabetes Detection sponsored by Disease Detection Information Bureau of Chicago,** Sheraton-Dallas Hotel, Dallas.

Feb. 16-18 — **Sectional Meeting of American College of Surgeons,** St. Paul Hilton, St. Paul.

Feb. 17-20 — **Postgraduate Course of Surgery of the Hand sponsored by University of Colorado School of Medicine,** Humphreys Postgraduate Center, Denver.

Feb. 18 — **Postgraduate Course in Office Pediatrics,** University of Nebraska Medical Center, Omaha.

Feb. 18-20 — **Frontiers of Medicine 1970 sponsored by Lakeland Graduate Medical Assembly,** Lakeland, Florida.

Feb. 19-20 — **Postgraduate Course in Clinical Otorhinolaryngology,** University of Nebraska Medical Center, Omaha.

Feb. 20-22 — **Symposium on Rheumatic Diseases sponsored by New Mexico Chapter Arthritis Foundation,** Kachina Lodge, Taos, New Mexico.

Feb. 23-27 — **Gastroenterology for Clinical Teachers sponsored by American College of Physicians,** University of Michigan Medical Center, Ann Arbor.

Feb. 25-26 — **Postgraduate Course on Selected Topics in Basic and Clinical Immunology,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.

Feb. 25-Mar. 1 — **19th Annual Scientific Session of American College of Cardiology,** Rivergate Center, New Orleans.

Mar. 1-4 — **Midwest Clinical Conference of Chicago Medical Society,** Sherman House, Chicago.

Mar. 2-4 — **Clinical Concepts in Infectious Diseases: Manifestations and Management sponsored by American College of Physicians,** University of Florida, Gainesville.

Mar. 2-6 — **Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta, Georgia.

Mar. 5-6 — **Postgraduate Course on Advances in Hematology sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Mar 9-13 — **Postgraduate Course on Cardiology and Renal Disease: Patho-Physiology and Pharmacology sponsored by American College of Physicians,** Presbyterian-St. Luke's Hospital, Chicago.

Mar. 9-27 — **Postgraduate Course in Occupational and Environmental Medicine sponsored by New York University Postgraduate Medical School,** New York University Medical Center, New York.

Mar. 11-12 — **Postgraduate Course on Current Management of Common Orthopaedic Problems,** Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

Mar. 12-14 — **Postgraduate Course on Infectious Diseases sponsored by University of Wisconsin,** Madison.

Mar. 16-18 — **Postgraduate Course on Pediatrics,** Kansas University Medical Center, Kansas City, Kansas.

Mar. 16-18 — **Sectional Meeting of American College of Surgeons,** Sheraton Park Hotel, Washington, D. C.

Mar. 16-20 — **Clinical Problems in Internal Medicine sponsored by American College of Physicians,** Cleveland Clinic, Cleveland.

Mar. 18-20 — **Annual Scientific Meeting and Third Post-Graduate Course of American Fertility Society,** Washington-Hilton Hotel, Washington, D. C.

Mar. 19-20 — **Postgraduate Course on Obstetrics and Gynecology sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Mar. 20-21 — **Fourth National Congress on Socio-Economics of Health Care,** Palmer House, Chicago.

Mar. 23-25 — **Postgraduate Course on Surgery,** Kansas University Medical Center, Kansas City, Kansas.

Mar. 23-26 — **Neurology and the Internist sponsored by American College of Physicians,** Mayo Clinic and Mayo Graduate School of Medicine (University of Minnesota), Rochester.

Mar. 25-26 — **Postgraduate Course on Medical Progress and Its Relationship to Dentistry,** Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

Mar. 30-31 — **Postgraduate Course on Psychiatry in General Practice sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Mar. 30-April 3 — **Postgraduate Course on Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment sponsored by American College of Physicians,** University of Michigan Medical Center, Ann Arbor.

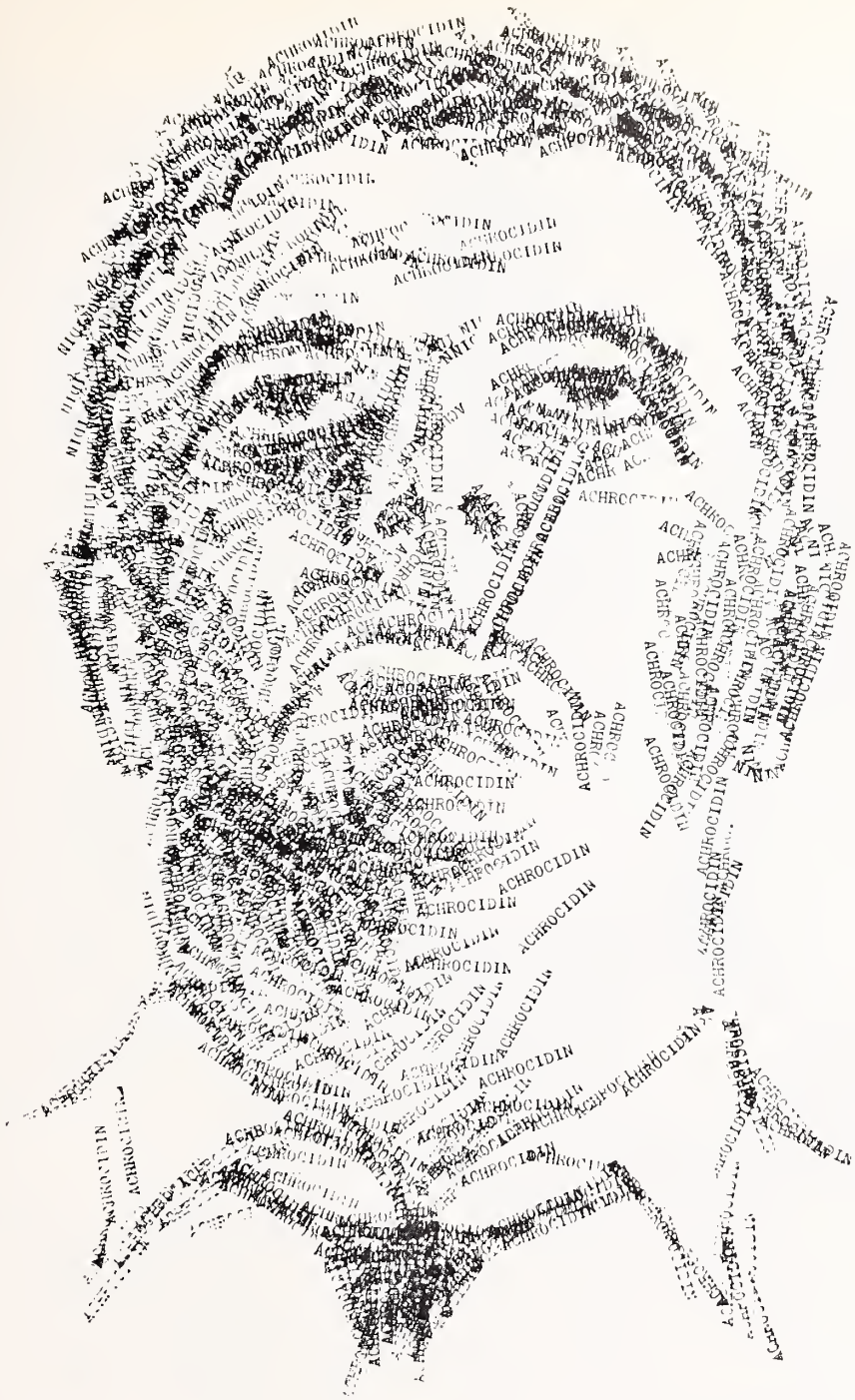
ABROAD

Feb. 1-14 — **International Congress on Alcoholism and Drug Dependence (29th),** Sydney, Australia.

Feb. 14-19 — **Symposium of Sports Medicine with International Participation,** Vysoke Tatry, Czechoslovakia.

Mar. 8-14 — **International Congress of Ophthalmology (21st),** Mexico City.

(Continued on page 113)



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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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Scientific Articles

Interrupting the Family Cycle of Violence

RICHARD L. JENKINS, M.D.,
ROBERT GANTS, M.A.,
TAKESHI SHOJI, M.A., and
EDNA FINE, M.S.W.

LEGISLATION ENACTED by the General Assembly of Iowa in 1965 places upon every health-care practitioner the responsibility for reporting to the county department of social welfare all instances of physical injury to children which are attributable to abuse or willful neglect.

Most instances of "the battered child syndrome" occur during the first five years of life. Infants and young children are particularly vulnerable to serious injury by parents who have passed their frustration tolerance, and who are impulsive or inadequate as regards self-control. Some children—the irritable youngster, the constantly crying baby, the hyperactive child and the child who fails to maintain toilet habits—are particularly trying on parental patience.

The usual picture is that of a parent pushed beyond the bounds of a limited tolerance for frustration. For example there is the mother who felt rejected by her own parents, who has experienced subsequent real rejections, and who has looked to her baby as the one human being who will really accept her. She may react to the infant's continued crying as another rejection, and in utter frustration may strike the infant. Such parents need understanding and help in developing emotional maturity and self-control.

Not only does a battered child tend to become a battering parent, but occasionally a family pattern of violence develops in which a battered child batters younger children. The following is an instance of the latter situation.

A surgeon phoned one evening to report finding a baby on a children's surgical ward who had sustained 13 fractures of 12 long bones, and another baby who had sustained two fractures. It seemed clear that the arms and legs of the babies had been pulled through the crib bars and levered back and forth to produce the fractures.

The suspect was a convalescent nine-year-old boy whom we shall call Fred. After he was interviewed, Fred was immediately transferred to the Child Psychiatry Service at University Hospitals, thereby relieving some of the tension which understandably had developed on the children's surgical ward. He was a rather unhappy looking boy with a right facial paralysis. He spoke little, seemed timid and was quite inhibited. Sixteen days previously he had been taken by his mother and stepfather to a physician's office in a neighboring small city because of a triangular scalp wound in the left parietal area. The physician had looked into

Dr. Jenkins is chief of the Child Psychiatry Service in the Department of Psychiatry at the U. of I. College of Medicine. Mr. Shoji is a psychologist from Tokyo, recently at University Hospitals, Iowa City. Mr. Gants is director of clinical services at Orchard Place, Des Moines. Mrs. Fine is a social worker at University Hospitals.

the wound, and after seeing cerebral tissue and giving immediate treatment, had referred the boy to University Hospitals. There, an x-ray revealed a left parietal skull fracture. When Fred's head was shaved, many scalp scars, thought to be of varying ages, became evident. When the skull fracture was treated surgically, bone was found to have been driven into the brain for approximately an inch. The depressed bone was elevated and a debridement was carried out. He was treated with antibiotics and placed on an anticonvulsant medication (diphenylhydantoin).

Fred was reported to the authorities in his home community as a battered child. For two weeks his convalescence was uneventful except for a right facial paralysis and apparently some interference with his speech. Then, on a Sunday, his mother and stepfather came to visit him and he was faced with the prospect of returning home. On Monday the two babies were found injured.

The report of those injuries galvanized the local authorities into action, and the stepfather was sentenced to 30 days in jail for child abuse. The mother asked the county department of social welfare to place Fred's older brother in a foster home, and that was done. The mother admitted that her husband had characteristically been harsh with those two boys, but she said she had never thought he would injure them. Fred and his older brother had been in the same special-education class, and the school authorities had observed repeated evidence of minor injuries on them, such as black eyes. In general Fred had been silent and had let his older brother speak for him, but both boys had told their teacher of their wish to kill their stepfather because he was in the habit of beating them. By way of contrast, the school had seen no evidence of the man's having abused his own children, who of course were younger than these stepsons.

Fred had sustained his most recent and severest injury while he and his two brothers were out with his stepfather on a trapline that he visited weekly. Initially it had been reported that Fred had slipped on the ice and had fallen on a "turtle hook," a three-foot metal bar with a T-shaped end. Later the stepfather admitted that he had pushed Fred, and the boy had fallen on the turtle hook. According to the other boys, however, the stepfather had struck Fred over the head with the implement.

During the first interview Fred was notably apprehensive and guarded on the most innocuous topics, but he gave a clear picture of being unwanted by his younger brother and his stepfather, and of suffering frequent very severe punishments at the hands of his stepfather. When asked whether his parents' visit had pleased him, he remained silent and was clearly unhappy. He was silent when asked why he had pulled the babies' legs, but when asked whether he was sorry he had done it, he responded with a firm "Yes."

Fred spoke very little after his admission to the Child Psychiatry Service. His speech was somewhat slurred—a phenomenon probably related to his right facial weakness. He was quite shy and quiet, and turned away whenever he was confronted directly. Yet he sometimes smiled shyly in response to friendly overtures.

Fred's mother had been the seventh of nine children. In childhood she had frequently been beaten by her father. At 14, she began 2½ years in a tuberculosis sanitarium. After finishing the ninth grade, she married a man whom she described as one of four children his mother bore in an incestuous union with her own widowed father. Of her two children by that husband, the second was Fred. That husband spent three or four periods in a mental hospital during their marriage. They separated when the mother was a month pregnant with Fred, and a divorce was granted her on grounds of mental cruelty. That husband subsequently died in a mental hospital.

Fred's stepfather was a laborer who worked a trapline on weekends. He had been the seventh of eight children, and had been "cuffed around" frequently. He had married a woman who had had three or four previous marriages, and had divorced her because of her relationships with other men. He had never married

Conference on
THE BATTERED-CHILD SYNDROME
U. of I. College of Medicine, Iowa City
Friday, May 8, 1970

Fred's mother, but they had lived together in a common-law relationship for eight years, during which she had borne him five children.

It was difficult to test Fred psychologically because he spoke so little. Initially his verbal IQ was in the borderline range, and his performance IQ was low average. Six months later his performance IQ was middle average, and his verbal IQ was at the upper end of the dull-normal range.

Projective stories gave indication of an emotionally deprived child who felt helpless and unable to cope with his environment. A test involving family relations produced both obvious anxiety and a denial of resentful feelings between family members.

The electroencephalograph showed moderate to marked diffuse and asymmetric slow abnormality, with diffuse slow theta background for age, left anterior temporal depression, and adjacent left parietal-central increased voltage suggestive of maximum abnormality in that region.

The daily ward-charting showed that Fred was shy, timid, submissive and somewhat seclusive for two weeks. Then the shyness, timidity and submissiveness disappeared. Some seclusiveness remained, punctuated with decided outbursts of defiance, temper, foul language and assaultiveness. Those outbursts occurred at irregular intervals—perhaps once a week.

Almost daily treatment contacts with one of us (Mr. Shoji) were devoted to construction projects involving paper-folding, soap sculpture and the like, and games. Initially Fred was quite fearful, but he soon came to enjoy the activities, often humming as he worked. That initial "honeymoon period" lasted about a month. As he became more confident he also became less conforming, sometimes showing wild excitement and sometimes passive-aggressive behavior. He was in frequent conflict with other children, and often reacted unfavorably to that conflict during his therapy hour. Winning at games became very important to him, and he often cheated in an effort to win. That period lasted six weeks. At the end of it, the therapist began working with the recreation staff, seeking to improve Fred's relationships with other children. That third period lasted eight weeks.

With this change in emphasis, Fred showed much improvement. Almost all of the previously noted problems disappeared. His participation improved, and he began to play by the rules. The wild excitement which had often been present disappeared, and was replaced by steady effort and increasingly good sportsmanship.

When the children were taken to a summer camp for three days, Fred enjoyed himself very much and participated very well. His communication became free, open and direct. He obviously enjoyed the outdoors, and demonstrated considerable expertise in the matter of catching frogs. On a night frog-catching excursion, he amazed his therapist by dramatically talking to and for the frogs.

After seven months on the Child Psychiatry Service at University Hospitals, and after a preliminary visit and some conferences, Fred was moved to Orchard Place, a residential treatment center in Des Moines. It was thought that with continued psychotherapy he was ready for the small-group living units there. Initially he still was very inhibited in his speech. He kept his appointments with his new therapist (Mr. Gants), but he effectively resisted talking much about himself. He was willing to talk about other children or about his pets. As he became more comfortable with his therapist, he gradually became able to discuss his nightmares of gorilla-like monsters, his struggle to control his desire to hurt other children, his fear and belief that he would be like his stepfather, and his ambivalence toward his mother, who had permitted his stepfather to abuse him, but yet brought him many gifts when he was in the hospital.

Fred's therapy was still difficult because of his poor perception of social reality. What first seemed to be a reluctance to answer, later appeared to be an inability to concentrate or to absorb what was being said. His consequent fear and embarrassment led him to withdraw from a discussion. He was a responsible participant in group therapy, but still was very careful of what he said.

In the cottage Fred was liked by all of the other children and always seemed to have three or four friends—usually older boys whom he idealized. He was accepted more for his willingness to do what others wanted to

do than for any more positive qualities. Fred enjoyed physical contact, but at first could show affection for others only by playfully punching boys on the shoulders. In time, he allowed himself to be held by older girls in residence, but took their attention very passively. With one exception, Fred avoided all fights, and when angered he usually withdrew to his room to draw pictures. That activity usually was followed by a period of giddiness. However a six-year-old boy who provoked Fred became the object of his anger and aggression. Many times it was necessary to protect the younger lad from Fred. Most of the abuse that Fred actually inflicted upon him occurred when staff members could not observe it. On one occasion Fred sat on the boy, pounded him and then urinated on him. Later, in therapy, Fred told of similar acts by his stepfather against him. Fred also would mutter obscenities under his breath to members of the child-care staff when they placed demands on him. He also was very much preoccupied with pet turtles and birds, and spent much time caring for them.

Fred entered Campus School upon admittance to the program. His work was on the third-grade level, and below average, but his teachers felt that he struggled with specific problems in the classroom, almost to the point of obsession. Eventually he would become quite exhausted, and would spend the rest of the day dreaming or drawing pictures.

In an effort to support Fred against his insecurities, a parental-force worker functioning in foster-home placement and continuing foster-home supervision established contact with him on his first day at Orchard Place, and established a positive relation through continuing contacts. A foster home was found for him after four months, and visits were begun. The foster father (a deputy sheriff) had a close relationship with Fred from the start, and the boy wanted to leave Orchard Place earlier than his therapist felt desirable. After nine months he was placed in the foster home. He then entered a nearby public school, and made a satisfactory adjustment.

Therapy contacts were continued for the first two months that Fred was in the foster home. He showed growth in capacity to recognize and express resentment in socially acceptable ways, rather than suppress his resentment until it broke through with explosive violence. It was our impression that the foster father, with his masculine and acceptably aggressive adjustment to life, sanctioned enough aggressive expression to promote this change in the boy.

This happy arrangement terminated when Fred's foster father decided to take a much better-paying job in a distant city. It was a blow to Fred, and he returned to Orchard Place, where in the meantime his older brother had been admitted. The boys lived in separate buildings, and Fred did not revert to his former habit of depending upon his older brother to speak for him. (It was not surprising to us that Fred's brother had had to leave two foster homes because of sexual activities with children there, and for beating a crippled foster child in one of the homes.)

At the same time that Fred lost his foster parents, his parental-force worker also departed. He seemed able to establish a relationship with her replacement. After two months at Orchard Place, he was placed in a farm foster-home just outside the city. His adjustment there has been good. After 15 months in this placement, he is reported to have made many friends and to be very close to his foster father, with whom he hunts, fishes and does chores. He is considered a member of the family. He is getting on without rivalry with a foster brother who has also been placed in this home. He has moved out of a special education class, and is in a slow section of a sixth-grade class. He is no behavior problem in school, and is making better school progress.

DISCUSSION

Discussion about or with a boy as non-verbal as Fred is difficult.

We may regard the 15 fractures as the result of an outburst of violent resentment toward a brutal stepfather which was displaced upon two helpless infants. The action includes elements of identification with the aggressor, and taking out on the helpless infants intense feelings of hatred felt toward that aggressor, the stepfather.

Fred had experienced early love and nurture

from his mother. Many times he had experienced violent brutality from his stepfather. This brutality led to feelings of resentment experienced at a level of hatred. Yet the hatred was not pure, for it was mixed with elements of grudging yet unmistakable admiration. Fred was not conscienceless, as the thoroughly rejected child is very likely to be. Often he was driven by an overpowering fear, and sometimes by an almost overpowering hatred.

He let his older brother speak for him, and was relatively silent. It was very hard for him to learn a reasonable balance in behavior. He was silent and inhibited when dominated by fear, and if this wore off, he was obstreperous and difficult to control. Though he gradually gained faith in others, he remained suspicious of himself and feared an explosion of the aggressive feelings within him. He feared loss of control. He feared that he would be like his stepfather—and on occasion he *was* like him. Under emotional strain it was very hard for him to find a pattern of healthy assertiveness between fearful inhibition and aggressive loss of control. The mistreatment which he evidently experienced was not only violent but involved assaults on the most elementary vestiges of human decency and human dignity, in sexual abuse and physical degradation. Fear and/or hatred were the only reasonable responses. Fred seemed able to function in social relations and in school, yet experiences such as he has had can never be completely erased. It is our hope that his responses have been sufficiently modified to permit him a reasonably normal life.

The Three-Century History of

An Iowa Family With Huntington's Chorea

RICHARD FINN, M.D.
Iowa City

HUNTINGTON'S CHOREA CAME to Iowa with the pioneers. It is a degenerative brain disease transmitted by an autosomal dominant gene and characterized by the development of chorea and dementia in middle life.[1, 2] The earliest patient known to have developed the disorder in this state was born in New York State in 1817, and came to Iowa with her physician husband. The first native Iowan to become choreic was born in Van Buren County in 1848. During the past century, Huntington's chorea has afflicted more than 590 Iowans, of whom over 100 were living during the present decade.[3]

Iowa's population is small and its history has been relatively short, but it has an established place in the chronology of knowledge about Huntington's chorea. Dr. Charles O. Waters[4] wrote the first published report about this hereditary type of chorea shortly after graduating from Jefferson Medical College, in Philadelphia. He then traveled to the western frontier and settled in Muscatine, Iowa, in 1844, where he practiced until he left medicine in 1859 to become an ordained Presbyterian minister. The last position that he held, before his death in 1892, was that of financial agent for the German Theological Seminary in Dubuque.[5]

In 1908, Arthur S. Hamilton[6] alerted American neurologists, alienists and asylum superintendents to consider the disease in choreic patients whose families *could not* be traced back to the eastern shores of Long Island where George Huntington, his father and his grandfather had tended the people whose hereditary disorder the youngest Huntington traced so carefully.[7] For many years Dr. Hamilton was the pathologist at the Independence, Iowa, State Hospital for the Insane, searching for the degenerative processes which would explain mental disease—a task that occupied the atten-

Dr. Finn is an assistant professor of psychiatry at the U. of I. College of Medicine.

tion of many pathologists in those days. During his stay at Independence he examined, investigated and diagnosed Huntington's chorea in 27 patients.

Before Dr. Hamilton's report, American choreics were all assumed to be relatives of Huntington's Long Island families, despite conflicting family histories and many reports of the disease from foreign countries. Hamilton traced the families of many of the Independence patients to the British Isles and continental Europe. The families of the remainder were found to have come from New England and the Middle Atlantic states. None were traced to Long Island.

Eight years after Hamilton's report, the famous geneticist Charles B. Davenport, of the Carnegie Institution, and his colleague Dr. Elizabeth B. Muncey published a monumental study of Huntington's chorea.[8] Theirs was an extraordinary genealogical survey of four families that had come to colonial New England in the early seventeenth century. Davenport and Muncey identified 4,370 members and descendants of those immigrants, 962 of whom had developed chorea by 1910. Their study followed the migration of those families throughout New England to the Middle Atlantic states, to the Midwest, and eventually to the Pacific Coast.

Only two descendents of the four families were known to have settled in Iowa. In a recent study of my own,[3] Huntington's chorea could not be found to have afflicted any of them or of their descendants. However a third family member whose adult life was unknown to Davenport and Muncey eventually settled in Iowa and developed chorea. The account of her, and of her forebears and descendants has been put together from the memories of her surviving relatives, from hospital records, and from the work of Davenport and Muncey and several medical investigators and historians. That Iowa family and its history of Huntington's chorea constitute a record that now is nearly 340 years old (Figure 1).

CHOREA AND SEVENTEENTH CENTURY WITCHCRAFT

In the year 1630 the John Winthrop Puritan fleet, with 700 passengers, anchored in Boston Bay. Among the passengers were three men to whom Vessie[9] gave the fictitious names Jeffers, Nick and Willie. They had come from the village of Bures, in Suffolk County, England. Nick and Willie were brothers, and the wives of Jeffers and Nick were sisters. Those women had two sisters who either were also aboard the Winthrop fleet or came to the Bay Colony shortly thereafter. Those seven people from Bures, England, brought Huntington's chorea to America, and were the forebears of the families studied by Davenport and Muncey.[9, 10]

Old records show that in their first two decades in the colonies, members of the Bures family group were accused of theft, quackery, disorderly conduct, illicit sale of liquor, drunkenness, public prostitution, pauperism, religious dissention, family feuds, public profanity, "distemper," "bestialitie" and the harboring of runaway bondsmen. Nick and Willie remained bondsmen the rest of their lives, never being allowed to become freemen. Primarily responsible for Nick's remaining a bondsman was the fiery Baptist Roger Williams.[11] In time, Williams' violent attacks upon lawless settlers such as the Bures group left him with few protectors and many enemies, and he fled into the wilderness, later to found the colony of Rhode Island. Vessie asserted that George Huntington had the idea that one basis for supposing that chorea was a curse of the Lord was the legend that the ancestors of the Long Island families had persecuted Roger Williams. Muncey and Davenport have shown that the Long Island choreic families were descendants of Willie's granddaughter.

The history of the Bures family group in colonial New England also includes a considerable involvement with the very serious religious problem of the time, witchcraft. Seven women in the Bures group were accused of being witches. First, Willie's daughter-in-law Elizabeth left her husband and returned to England, where she was hanged for witchcraft. Her daughter Elizabeth, who had been left behind in the colonies, later became known as the Witch of Groton. Reverend Cotton Mather, the celebrated Puritan witch-hunter, wrote of her in his MAGNALIA CHRISTI AMERICANA, and from his Boston pulpit in 1671, he called for her hanging. She did not hang, but what happened to her thereafter is unknown.

One of the notable trials for witchcraft ended in the hanging of Nick's wife, Ellin, at Fair-

field, Connecticut, in 1653.[12] Her body was cut down, afterward, and put on display, nude, so that examiners could look for the physical stigmata of Satanic possession. Ellin's sister Mary insisted on examining the body too, and then, in a frenzy of grief and anger, she declared that if Ellin had the markings of a witch, so did she and every other woman present. The magistrate attempted, unsuccessfully, to have her declared a witch on the spot.

In 1692 Mary, her daughter Mary, and her granddaughter Hannah were accused of witchcraft and were tried by the Fairfield Court, as were three other women including Ellin's granddaughter Mercy. Mercy failed the witches' water test—i.e. when she had been thrown into the water she floated, and thus could not drown to prove her innocence! All six were acquitted, however, when the judges decided that their mischievous accuser was "counterfeiting."

INTERMARRIAGES AMONG CHOREICS

There were remarkably many consanguineous marriages among the descendants of the Bures family group. Three of those marriages are indicated in Figure 1 by double lines between spouses. How can that propensity for marrying a relative, usually a cousin, be explained? In the early generations the background and antisocial behavior of those people, plus the accusations of witchcraft that had been made against them may perhaps have accounted for it. Another explanation might be that seeing and being frightened by a choreic individual might make people wary of the patient's relatives.

Here is George Huntington's recollection of his first meeting with choreics:[13]

> Over fifty years ago, in riding with my father on his professional rounds, I saw my first case. . . . I can recall it as vividly as though it had occurred but yesterday. It made a most enduring impression upon my boyish mind, an impression every detail of which I recall. . . . Driving with my father through a wooded road leading from East Hampton to Amagansett, we suddenly came upon two women, mother and daughter, both tall, thin, almost cadaverous, both bowing, twisting and grimacing. I stared in wonderment, almost in fear. What could it mean?

A more telling explanation for the many consanguineous marriages has to be that the hereditary nature of the disease became apparent to the affected families over the years, and to their neighbors. Lyon[14] wrote of it in 1863, seven years before Huntington's paper:

> So strong is the conviction of its hereditary influence that the people among whom it occurs believe this to constitute its only legitimate method of propagation, and acting accordingly have repeatedly been known to interdict marriage alliances between their children and those believed to be tainted with the migrim diathesis, under the severe penalties of disinheritance and social ostracism.

Shunned, isolated and rejected, what was a young man or woman from one of these families to do? Some of them married their kin. Others moved far away, changed their names, broke all relationships with their families, and told no one of their past. But with Huntington's chorea, out of sight is *not* out of mind.

CHOREA WAS THE THEME OF AN O'NEILL PLAY

The American playwright Eugene O'Neill grew up in an area having a considerable concentration of Huntington's chorea. It is likely that he saw choreics as a young man, and like George Huntington never forgot them. In his play STRANGE INTERLUDE,[15] he writes of a family with a hereditary mental disease, and in one of the more dramatic scenes shows a newly-married woman learning of the family illness from her mother-in-law:

> *Mrs. Evans:* I thought I was plain, but I'll be plainer. Only remember it's a family secret, and now you're one of the family. It's the curse on the Evanses. My husband's mother—she was an only child—died in an asylum, and her father before her. I know that for a fact. And my husband's sister, Sammy's aunt, she's out of her mind. She lives on the top floor of this house, hasn't been out of her room in years; I've taken care of her. . . . I remember when she was all right; she was always unhappy; she never got married; most people around her were afraid of the Evanses in spite of their being rich for hereabouts. They knew about the craziness going back, I guess, for heaven knows how long. I didn't know about the Evanses until after I'd married my husband. He came to the town I lived in; no one there knew about the Evanses. He didn't tell me until after we were married. He asked me to forgive him; he said he loved me so much he'd have gone mad without me. . . . We'd swore we'd never have children; we never forgot to be careful for two whole years. Then one night we'd both gone to a dance; we'd both had a little punch to drink, just enough—to forget—driving home in the moonlight.

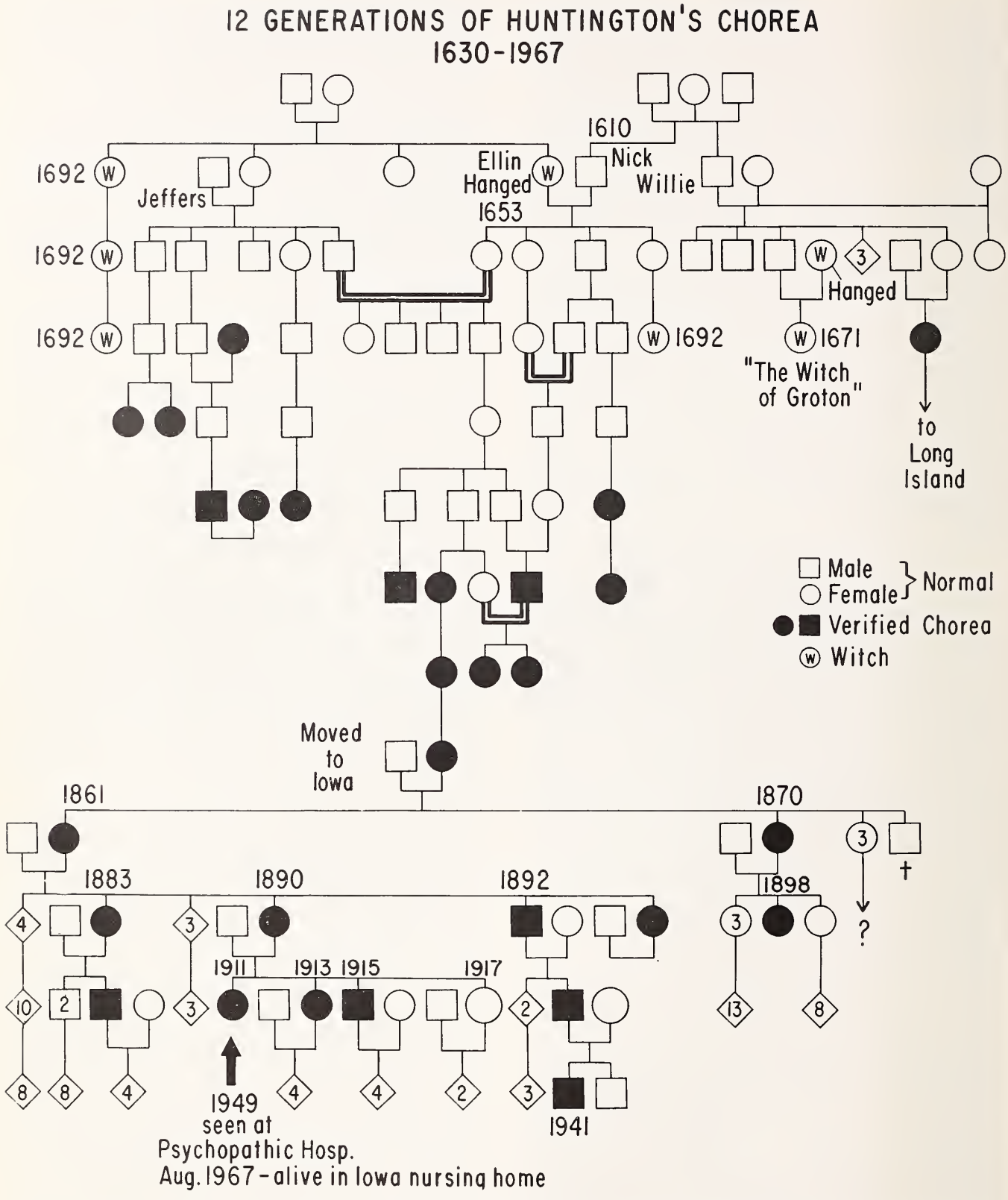


Figure 1. The pedigree of the Iowa family showing its relationship to the many collateral lines of Huntington's chorea descending from the Bures group and the involvement of early family members in colonial New England witch-hunts. The explanation provided for the symbols used in the table is incomplete. The "diamonds" represent progeny undifferentiated as to sex, and the enclosed numbers tell how many there were in each instance. The white circles containing numbers indicated unaffected daughters, and the cross means that the boy represented by the near by white square died in childhood.

DESCENDANTS OF THE BURES GROUP IN IOWA

The writing of Lyon and O'Neill may help us to understand the circumstances by which the choreic gene of the Bures family group came to Iowa. It came in the person of a young woman born in New York State, where she had many affected relatives. Her immediate family stayed in New York. Before the Civil War, she married a man who was born and brought up in Iowa. The couple's first child was born in Iowa in 1861. Had he gone east to find a wife willing to share the dangers and privations of what was still the frontier? Or had she fled to the West, away from her family, its illness and its reputation?

The couple's two oldest daughters developed chorea in later life, as their mother had done before them. The oldest daughter had 11 children, and chorea developed in four of her youngest five. Her ninth child, a daughter born in 1890, died of chorea in a northern Iowa city shortly after World War II. Chorea developed in three of her four children. Her oldest daughter was seen at the Iowa Psychopathic Hospital for a paranoid state in 1949, two years after the neurologic symptoms became manifest. Twenty-one years after her illness began, while confined to a nursing home, she died of aspiration pneumonia—a common cause of death in choreics. The second oldest daughter developed Huntington's chorea and died in 1961, leaving four children. The only son, also a choreic, lives in a neighboring state with his four children. The youngest daughter, unaffected, lives in the family home with her two children—waiting.

ADDENDUM

Recently, Hans and Gilmore[16] have questioned the accuracy of details in the widely quoted Vessie paper[9] from which were drawn some of the conclusions about the relationship of the early choreic families to events in colonial times. However, the genealogy of the Iowa family was drawn from another source, Davenport and Muncey,[8] courtesy of Dr. Sheldon Reed, of the Dight Institute of Human Genetics at the University of Minnesota.

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Idiopathic Thrombocytopenic Purpura in Childhood: An Approach to Therapy

JAMES C. TAYLOR, M.D.
Iowa City

Idiopathic thrombocytopenic purpura (ITP) is the most common acquired bleeding disorder of childhood. It usually is manifested by the sudden onset of extensive cutaneous hemorrhages, either spontaneous or secondary to trauma, and in the majority of cases remissions occur within a few weeks to several months. The condition was first described by Werlhof in 1775, but a century elapsed before the relationship between it and a diminished number of circulating platelets was noted. Although much has subsequently been learned about the disease, controversy still exists as to its cause and treatment.

CLINICAL ASPECTS

Although there is a three-to-one predominance of females among adult patients, there is equal prevalence in the two sexes in children. In 50 to 80 per cent of the cases there is a history of viral illness within two weeks of the onset of symptoms. Rubella, rubeola, varicella, infectious mononucleosis and non-specific upper respiratory tract infections have been implicated.[1, 2] Symptomatic thrombocytopenia has also been reported following the administration of live measles vaccine.[3]

The usual chief compaint is easy bruisability. Cutaneous hemorrhages varying from petechiae to large ecchymoses are common, as are epistaxis and bleeding from the mucous membranes. Occasionally, significant gastrointestinal hemorrhage or bleeding into the genitourinary tract is noted. Fortunately, hemorrhage into the central nervous system is rare, with an incidence of no more than 2 to 4 per cent, and it usually occurs during the initial period of illness.[4, 5]

Significant hepatosplenomegaly is unusual, and if combined with lymphadenopathy it suggests that the thrombocytopenia is secondary to an underlying disease process such as leukemia or lupus erythematosus. In the event that the preceding viral illness is responsible for the hepatosplenomegaly, as in infectious mononucleosis, specific laboratory studies will establish the diagnosis.

DIAGNOSIS

Generally the peripheral platelet count is below 50,000 and in the majority of cases it is lower than 20,000/cu. mm. With platelet counts above 20,000/cu. mm., spontaneous hemorrhage is unusual, although bruising as a result of minor trauma will be present. Ancillary clotting studies which depend on adequate platelet function, such as bleeding time and the tourniquet and clot-retraction tests, are abnormal, but ordinarily they are not needed to establish the diagnosis. The clotting time and prothrombin time are within normal limits. Unless significant blood loss has occurred, anemia is usually absent, and the white count it normal. The peripheral smear will show reduced platelets, and often the few platelets present are large and abnormal.

Evaluation of the bone marrow is essential for proper diagnosis, and is useful in excluding other diseases. The megakaryocytes may be normal in number, or more numerous than usual. If there is a diminution in the number of megakaryocytes, toxic depression of the marrow secondary to chemical agents or infections should be suspected. With excessive blood loss, erythroid hyperplasia is not uncommon, and for reasons yet unknown increases in the number of marrow eosinophils are frequent. It has been stated that marrow eosino-

Dr. Taylor is an assistant professor of pediatrics at the U. of I. College of Medicine, and pediatric hematologist at University Hospitals.

philia portends a favorable prognosis, but that assertion has not been confirmed.

Disseminated lupus erythematosus has, on occasion, presented as an unexplained thrombocytopenia, and in the proper evaluation of a child with thrombocytopenia, particularly in the older age group, an LE preparation is indicated. An association of idiopathic thrombocytopenia with an auto-immune hemolytic anemia has also been noted, and should there be a significant anemia with evidence of hemolysis, a Coomb's test should be done.[6]

In children an acute onset of symptoms following a viral infection, a low platelet count and the characteristic findings in the bone marrow are usually sufficient to establish the diagnosis of idiopathic thrombocytopenic purpura.

ETIOLOGY

It is believed that idiopathic thrombocytopenic purpura is immunologic in origin. When plasma from a patient with the disease is transfused into a normal individual, a profound thrombocytopenia develops. Since a mother with active idiopathic thrombocytopenia will often deliver a child with thrombocytopenia, it is further suggested that the antibody is of the IgG type which readily passes the placenta. Clinical support for this concept is derived from the presence of thrombocytopenia in known immunologic diseases such as lupus erythematosus and acquired hemolytic anemia. *In vivo* animal studies have also strengthened this hypothesis, and platelet agglutinins have been demonstrated in 80 per cent of adults with ITP.[7]

Circulating platelet antibodies are inconstantly found in children with thrombocytopenic purpura, but the association of the disorder with a preceding viral infection strongly suggests that the virus is absorbed onto the platelet during the acute illness, and thus that it alters the structure in some manner, so that the platelets become antigenic.

Although the beneficial effect of splenectomy in idiopathic thrombocytopenic purpura has been known since 1916, the exact role that the spleen plays in the disease process is not clear. It has been suggested that the spleen elaborates a humoral factor which inhibits megakaryocytic function. This theory has not been proved. With isotopic studies it has been shown that the sensitized platelet is more readily removed from circulation by the spleen. In addition, the spleen is believed to be a major source of antibody production.[7]

TREATMENT

If the thrombocytopenia persists longer than six months, the disease is considered to be in the chronic phase. In contrast to adult patients with idiopathic thrombocytopenia, among whom there are only 30 per cent spontaneous remissions, 80 per cent of pediatric patients evidence a return of the platelet count to normal within three to six months after the onset of symptoms. Although the majority of children recover within six months, spontaneous remissions have been delayed as long as two to three years.

At the time of the initial evaluation, if there has been significant blood loss due to the thrombocytopenia, replacement by fresh-blood transfusions is indicated. Despite the fact that there is experimental evidence of transfused exogenous platelets' being rapidly sequestered and destroyed in the spleen, platelet-rich plasma transfusions should be given if there is continued or life-threatening bleeding, such as might occur in the gastrointestinal tract or in the central nervous system.

A. *Steroid Therapy.* If it is accepted that idiopathic thombocytopenia is basically an immunologic disease, the use of immunosuppressive drugs such as the corticosteroids is justified. While it has been suggested that children treated with steroids take significantly longer times to recover than do those who have not received any specific medication,[2] the few deaths that have been reported occurred in most instances during the first month. Therefore therapy seems indicated where the child is believed to be in jeopardy because of severe bleeding. It has been observed that the hemorrhagic manifestations are diminished within several days after the patient begins such treatment, although no demonstrable change in the platelets has taken place. Presumably this happens as a result of the direct action of the corticosteroids on the capillary bed.

At the onset there is no way to predict which child will have a life-threatening hemorrhage and which one a chronic course, and likewise there is no way to predict which child will have a rather benign course and a rapid re-

mission. Nor is there any correlation between the hemorrhagic tendency and the absolute number of platelets, once the count falls below 20,000/cu. mm. It has been our policy, therefore, to treat the individual rather than to treat the platelet count. Cutaneous hemorrhages, *per se*, are not an indication for therapy. However where there is significant bleeding from the mucous membranes, where conjunctival or retinal hemorrhages are noted, where there is bleeding into the gastrointestinal or genitourinary tract, or where central nervous system bleeding is suspected, corticosteroids should be given. On the other hand, where symptomatic bleeding is limited to the skin, it is appropriate to observe the child for several days. If no further bleeding occurs and if the platelet count stabilizes above 20,000/cu. mm., treatment is not indicated.

The therapy of choice is oral prednisone, 1.5 to 2 mg./Kg./day, divided into three or four equal doses. If oral medications are not tolerated, an equivalent dose of intravenous hydrocortisone should be given. Unless there is significant bleeding or unless close observation at home is impossible, it usually is unnecessary to hospitalize the child. However one should warn the family about traumatic hemorrhages, and restrict the patient's activities, urging avoidance of such things as tree climbing, bicycle riding and contact sports that might cause an injury. In addition, intramuscular injections are contraindicated because of the danger of hematoma formation.

As previously mentioned, there is no way to predict which child will show a response to the steroid therapy. Occasionally the platelet count will rise to normal within five to ten days. On the other hand, although the manifestations of bleeding become less, no change in the total platelet count may be noted. Regardless of whether the platelet count returns to normal (above 150,000/cu. mm.) or whether there is *no* rise in the number of platelets at the end of three weeks, it is recommended that the prednisone be tapered over a seven-day period and then discontinued.

The platelet level may remain high after the discontinuation of prednisone, or the count—which initially was below 20,000/cu. mm. but rose above 150,000/cu. mm. on therapy—may fall again to 50,000 to 100,000/cu. mm. when therapy is stopped. The child will remain relatively asymptomatic, however, except for minimal bruising, and over a period of weeks or months the count will gradually return to normal. Where there has been no initial response to corticosteroids, a rise in platelets occasionally occurs when the prednisone is discontinued. It has been suggested that a sustained high dosage of prednisone has a thrombocytopenic effect, and continuation of high-dose therapy for a period exceeding three weeks is contraindicated.[9]

Since a spontaneous remission usually occurs within six months after the onset of symptoms, a single course of prednisone is often sufficient. Occasionally, however, a child will continue to have rather severe hemorrhages following the initial cessation of therapy. In these cases, after three or four weeks without the drug, a second course of prednisone should be tried, and if the hemorrhagic manifestations are controlled, even though the platelet count remains low, the dose should gradually be reduced to a level that seems to control the bleeding tendency. Often this is in the range of 5 to 15 mg. of prednisone daily. To minimize the side-effects of hypercorticosteroidism such as generalized osteoporosis and retardation of growth, an attempt should be made to reduce the dose further, to an every-other-day schedule.

Rarely, a child is found to be steroid-dependent, and the platelet level and, consequently, the clinical manifestations are directly related to the dosage of prednisone. In such a case it is recommended that a minimum dose of prednisone be found which will keep the child hemorrhage-free and his platelet count above 20,000/cu. mm. If a remission has not occurred after six months of such continuous therapy, the steroids should be discontinued, and the child should be considered for splenectomy.

Even though there may be an initial spontaneous or drug-induced response, a small number of patients have been reported in whom there were recurrent episodes of thrombocytopenia with intervening periods during which the platelet count and platelet survival were normal. Relapses following remissions by as much as 18 years have been reported.[10]

Thus, while corticosteroid therapy has no direct effect on the eventual outcome of the

disease, its use is indicated to prevent fatal hemorrhage in patients who presented initially with severe bleeding manifestations.

There is increasing evidence that in certain cases of idiopathic thrombocytopenic purpura —particularly in adults who are resistant to steroid therapy—the use of other immunosuppressive drugs—namely the purine antagonists 6-mercaptopurine and imuran—may be effective in producing a remission.[11] The response to these drugs seems to be greatest following splenectomy. The dangers inherent in such immunosuppressant therapy—the unavoidable side-effects of marrow depression—warrant considerable caution regarding the use of these drugs in children. The number of cases successfully treated by this method is too small to constitute the basis for a firm conclusion about its efficacy at the present time.

B. Splenectomy. Since the vast majority of children with idiopathic thrombocytopenic purpura undergo spontaneous remission within six months, relatively few enter the chronic phase, and splenectomies, therefore, are proportionately fewer in children than in adults. Occasionally in a child with severe hemorrhagic diastasis or one in whom there is continued significant bleeding in spite of steroid therapy, a splenectomy may be indicated within a few days to several weeks following the onset of the disease. However it is generally recommended that splenectomy be deferred for at least six months, and unless extenuating circumstances exist, that it be deferred for a year or a year and a half. If the platelet count remains above 50,000/cu. mm., and if the child is relatively asymptomatic and is leading a reasonably normal life, a postponement for as long as two or three years is justified. On the other hand, the child who is having significant bleeding, the child whose activities are markedly restricted by the disease, and the pubertal female with excessive menstrual bleeding—all these are candidates for splenectomy within a year following onset.

There is no way to predict the outcome of splenectomy with certainty. Of children with chronic idiopathic thrombocytopenic purpura, approximately 70 to 80 per cent show a complete and sustained remission following removal of the spleen. Even in those cases where there is a failure to maintain an elevated platelet count after surgery, the post-splenectomized child has a lowered bleeding tendency.

A temporary marked increase in the number of platelets may occur following removal of the spleen. Platelet counts in excess of 1,000,000/cu. mm. are not uncommon, but in the pediatric population they are well tolerated without thromboembolic complications. Therefore anticoagulation is not indicated.

It is well established that following splenectomy, children under five years of age have an increased susceptibility to overwhelming infection.[12] Since this is most often due to a pneumococcal septicemia, it is recommended that the younger ones of such children receive daily prophylactic penicillin for at least a year following removal of the spleen.

SUMMARY

Idiopathic thrombocytopenic purpura is a common disorder of childhood, often following an acute viral infection. Short-term corticosteroid therapy is indicated in any case where there is a significant bleeding diathesis. Long-term, high-dose therapy is contraindicated, but in an occasional case a small daily dose of steroid may be needed to control hemorrhages and maintain an adequate platelet level. Approximately 80 per cent of children with the disease experience a spontaneous remission within six months of its onset. In the remaining patients, if they continue symptomatic, splenectomy is indicated and permanent remission can be expected in 75 to 80 per cent of them following such surgery. Therefore, in the individual case the overall prognosis for recovery, either spontaneous or following splenectomy, is approximately 95 per cent.

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The Use and Misuse of Psychotropic Drugs

A Panel Discussion

Dr. Clancy: Last year we presented a panel discussion on drugs that are frequently used in psychiatric treatment. We have been requested to continue the discussion this year, but first I wish quickly to review the previous presentation. We excluded barbiturates and narcotic drugs from consideration, since we assumed everyone was familiar with the effects and problems associated with their use. The remaining psychotropic drugs in common use, we placed in three categories: (a) sedative hypnotic drugs and minor tranquilizers (meprobamate, glutethimide, ethinamate, ethchlorvynol, methyprylon, chlordiazepoxide, etc.); (b) major tranquilizers which include the phenothiazine class (chlorpromazine, trifluoperazine, thioridazine, etc.); and (c) antidepressant drugs, which include the tricyclics (Imipramine, amitriptyline) and the monoamine oxidase inhibitors (phenelzine, etc.).

The physician who wishes to prescribe a sedative, a hypnotic or a minor tranquilizer from the drugs mentioned in the first category has a large number from which to choose. The advertisers' emphasis upon the alleged non-narcotic and non-barbiturate nature of these compounds may convey a false sense of security about them. It is now apparent that when taken to excess, many of these drugs can cause intoxication and a degree of dependence. The clinical picture then resembles that produced by either alcohol or barbiturate intoxication, and unfortunately these drugs are sometimes combined with them. Intoxications cause periods of confusion and ataxia—progressing, in the more serious cases, to psychotic states in which hallucinations and convulsions may develop. The withdrawal symptoms which develop when drug dependence has been established usually commence with apprehension, insomnia, anorexia and weakness. Elevation of temperature, hypotension and convulsions occasionally develop. Generalized confusion, with or without perceptual disturbances, may appear and may last for a number of days.

In treating this state I believe it is essential to hospitalize the patient and also to withdraw the drug slowly. If you know what drug and what dosage have been employed, then prescribe a sufficient amount of that drug to keep the patient comfortable, and slowly reduce the dosage at the rate of one therapeutic dose per day. If withdrawal symptoms appear, hold steady on the dosage before reducing it any further. If the drug or the dosage is unknown or in doubt, and particularly if the patient has been taking mixtures of drugs, I believe it is better to substitute a barbiturate. Usually 0.2 to 0.4 Gm. of pentobarbital four times daily will make the patient comfortable and keep him in a state of near-intoxication. Stabilize the dosage at that level, and then reduce it slowly —by no more than 0.1 Gm. daily. If the patient is convulsing or in a psychotic state during the withdrawal period, you may have to give barbiturate intramuscularly or intravenously before instituting the regime I have described.

The second category of drugs we discussed were the major tranquilizers. The indications for these drugs, their effectiveness in psychotic

This discussion took place during the Refresher Course for General Practitioners cosponsored by the Iowa Chapter of the American Academy of General Practice and the U. of I. College of Medicine in Iowa City in February, 1969. The participants were Dr. John Clancy and Dr. A. S. Norris, professors, Dr. Hunter Comly, an associate professor, and Dr. Richard Finn, an assistant professor, all in the U. of I. Department of Psychiatry.

states, and the variety of side effects they produce are well documented. Physicians are quite familiar with these drugs, but I should like to mention two conditions observed in a few patients who have been on high dosages of these drugs for prolonged periods of time. The first is a slate-blue discoloration of the skin which, in addition, may be associated with opacities that appear in the lens and cornea. The second condition is tardive dyskinesia, in which tic-like, choreiform or athetoid movements are seen. They are most noticeable about the face and mouth, and may be expressed as munching or grimacing sequences. When the drug is discontinued the condition may clear up, or it may not.

The last group of drugs we discussed were the antidepressants. The monoamine oxidase inhibitors are tricky, and are incompatible with some foods and drugs. I believe that the tricyclic antidepressants are now used much more extensively, and that the monoamine oxidase inhibitors are used as a second line of defense when therapeutic failure is encountered with the tricyclic group.

The foregoing has been a summary of last year's discussion, and I shall now give way to Dr. Norris, who will report on the use of these drugs and his experiences with them while consulting and treating a general-hospital population.

Dr. Norris: I shall confine my comments to the special problems that one finds in a general hospital. The reactions that occur in medical and surgical patients may be quite different from those found in a psychiatric hospital. This is probably because the patients are older, are debilitated because of medical or surgical illnesses, and often have cerebral arteriosclerosis or early senile changes. In addition, most general-hospital patients are on medications for other illnesses, and when a psychotropic drug is added, they experience unusual and at times distressing reactions.

Barbiturates are still used in elderly patients to assure sleep. They frequently produce agitation and confusion in those people. These side effects may be compounded if one adds still more barbiturate, and a toxic psychosis is often produced.

The minor tranquilizers may not be so minor when used in a general hospital. They are preferable to barbiturates, but particularly in elderly, debilitated patients it is possible to produce confusional episodes with diazepam (Valium) or with chlordiazepoxide (Librium).

Diazepam (Valium) should not be used in the presence of glaucoma, and of course there is a real danger of encountering that condition in many elderly people. The phenothiazines are well known, and I shall just briefly mention a couple of things that one should be aware of when he uses them. First is the possibility of hypotensive attacks—particularly in patients who have cardiovascular disease. It is very important not to treat such a hypotension with adrenalin or epinephrine. Noradrenalin or related compounds should always be used, since with epinephrine one may get a paradoxical further lowering of the blood pressure instead of the expected increase. If a patient is on a phenothiazine and for any reason requires a blood-pressure stimulant, it is far safer to use noradrenalin. In a patient with myocardial disease it probably is safer to use a drug like trifluoperazine (Stelazine) or fluphenazine (Prolixin), since these drugs appear less likely to produce a hypotensive crisis.

We all are familiar with the rauwolfia compounds. They are effective drugs in agitation, but they have largely been replaced, for this purpose, by the phenothiazines. They continue to be used for hypertension, and they can produce depression, occasionally to a profound degree, and one must be aware of this possibility.

A group of drugs which are very useful, but at times can be difficult to employ in a general-hospital setting, are the antidepressants. In many cases there are indications for antidepressant drugs in a general hospital, however, since many patients with organic illnesses become depressed.

Impramine (Tofranil) and chemically-similar antidepressants can produce agitation and anxiety. But we must recall that in a few patients they can produce sleepiness, and sometimes confusion. The antidepressants which have a sedative action, such as amitriptyline (Elavil), are particularly useful in a general-hospital setting because the patients there are frequently anxious as well as depressed. Unfortunately it is this very group of drugs which may produce an acute delirium in elderly patients who have early signs of brain damage or who

are debilitated for other reasons. The confusional episode may look very much like any acute delirium—delirium tremens, for example. The patient may be slapping away at "the bugs crawling across the bed," or may be frightened and disoriented as to time, place and person. The level of anxiety may approach panic, and for that reason the psychosis may be dangerous. One can avoid this reaction, usually, by giving small doses—about half the customary amount. Also, it may be safer to use a drug without sedative qualities, and to add a mild tranquilizer when anxiety is present.

In a general hospital the monoamine oxidase inhibitors should be used with even greater care. They must be used with special caution in combination with other drugs, and therefore one is more likely to get into difficulty with them in general-hospital patients. They should not be used with sympathomimetics, with sedatives or with anesthetics. Tranylcypromine (Parnate) must not be given with foods such as certain kinds of cheeses, broad beans or chianti wine which may contain tyramine. The monoamine oxidase inhibitors should be used only when other drugs have failed or are contraindicated, and then only with the greatest care.

Dr. Clancy: Not all of the drugs that affect the mind are classified as such. Many drugs used for conditions such as hypertension, cardiac failure, etc. do have an effect upon the brain, and there have been many advances in this field. I shall call on Dr. Finn to speak to you on this aspect of our problem.

Dr. Finn: Before getting to that topic, Dr. Clancy, I should like to note briefly some things that psychotropic drugs are reported to have done that nobody expected them to do. One of the most unusual drug studies during the past year involved patients with amyotrophic lateral sclerosis—a brain disease that neurologists had called a progressive disease without remission. Investigators at Yale and at the University of Florida report producing remissions in eight amyotrophic lateral sclerosis patients by giving them the antidepressant Elavil in doses of 100 to 150 mg./day. And they claim that they produced those remissions or slowed the progression of the disease for periods of up to one year.

Psychotropic drugs are also reported to have an ameliorating effect upon two of the rare inborn errors of metabolism. Librium reduced the formation of crystals in cystinuria, and the monamine oxidase inhibitor Marplan reduced the oxalate levels in hyperoxaluria.

The investigations of Elavil in amyotrophic lateral sclerosis and of Librium in cystinuria were the results of fortuitous events. The drugs had been prescribed as means of treating the mental states of the patients, and the changes that took place in their physical disorders were noted and then followed up. The discovery regarding the extra usefulness of the antidepressant Marplan in hyperoxaluria, however, was not in any way serendipitous. Its beneficial properties had been predicted on the basis of current biochemical knowledge, and it did what it had been expected to do.

This brings me to one of the points I want to make today. The pharmacologists took a great leap ahead 15 years ago with the introduction of psychotropic drugs such as the antipsychotics and the antidepressants. So far, we still can't explain how those drugs work, but we have gone about as far as we can go with them clinically. There isn't any new major impending breakthrough in the drug treatment of mental disease, with the possible exception of lithium in mood disorders, and no one can predict a new era in psychopharmacology on the basis of classes of drugs not yet formulated. What lies ahead—in fact what we are now experiencing—is a period during which many experiments will be performed with drugs that we are already using for a variety of purposes. They will be used for specific indications in mental disorders on the basis of neurochemical and neurophysiologic discoveries and theories. I now should like to discuss with you some clinical experiments in the treatment of depression that have been done recently, based on some of these hypotheses and findings.

After the antidepressants were introduced, in the middle 1950's, any attempts to explain depression had to take into account the pharmacology of those drugs. Consequently it was supposed that depressed patients had a metabolic disturbance of cerebral amines. There are two groups of cerebral amines: the norepinephrine group, known as the catecholamines, and the serotonin group, known as the indolamines. American researchers have bet on the catecholamines. Though more than 10 years

have gone by, the catecholamine theory hasn't yet helped the clinical management of depression. Meanwhile, the British and the Russians have kept their eyes on serotonin. And while Americans have propounded complex theories about the catecholamines, a highly competent group of British researchers, from time to time, have modestly reported on their use of tryptophan in the treatment of psychotic depression. Tryptophan is the aminoacid precursor of serotonin. The British added trypophan to a drug regimen of monamine-oxidase-inhibitor antidepressants, and so improved their performance that the results of the combined treatment matched the results of electroconvulsive therapy. One still can't do better than that! The Britons' findings seemed to point conclusively to serotonin imbalance as an important factor in depression, but we Americans paid no attention.

Next, a very peculiar study was done in Great Britain, in France and in this country on the brain-stems of people who had committed suicide. Collecting clinical materials of that sort was a pretty good trick in itself! At the same time, the brain stems of people who had died natural deaths were also collected. The two groups of brain stems were compared for their cerebral amine content, and it was found that the suicides' brain stems had significantly lower levels of 5-hydroxy-indolacetic acid, the metabolic breakdown product of serotonin, and that finding was thought to show that something might be wrong with the serotonin metabolism of those people's brain stems. Now this is a rather interesting finding, for last year a French neurophysiologist demonstrated that a drug called parachlorophenylalanine can produce intractible insomnia in rats and in cats for periods lasting several days. The drug inhibits the metabolism of serotonin, an adequate level of which is somehow needed in the brain stem if the subject—animal or human—is to get a good night's sleep.

Second, a Canadian psychiatrist (who in addition is an endocrinologist recognized for his work with the adrenal) gave dexamethasone to 17 people with psychotic depressive reactions. He primed them with dexamethasone and then added a tricyclic antidepressant, and he reports that all 17 markedly improved within only a week or so from the time he started the antidepressants. Why? No one can say for sure, but it may very well be that dexamethasone, by suppressing adrenal activity, prevented cortisol from activating a liver enzyme called tryptophan pyrrolase. This enzyme switches tryptophan away from the production of serotonin. A single dose of dexamethasone can thereby prevent a reduction of brain levels of serotonin for a matter of three or four hours. According to the Canadian's report, the dexamethasone was given at midnight, and the first beneficial effect noted was a dropout of the terminal sleep disturbance. Now in theory, one could stop the sleep disturbance in another way. One could use the gout drug xyloprim, because xyloprim suppresses the activity of tryptophan pyrrolase, even in the presence of cortisol, so that the serotonin levels would not suddenly drop in the middle of the night when cortisol levels rapidly rise.

All this helps improve the possibility that there is a serotonin imbalance as well as a catecholamine imbalance in psychotic depression. The possibility would become almost a certainty if still another clinical experiment holds up to replication. That experiment uses another drug which we all know—Sansert, the drug used in preventing migraine headaches. The experiment is especially notable since, for the first time in psychiatry, someone postulated a theory regarding the etiology of a mental disorder, then said a certain drug constituted the specific treatment, and then showed that the drug worked as predicted. At least an English investigator says it worked, and a group of Czechs have agreed. According to this theory, the cause of mania is that there is too much serotonin in the brain, and if one reduces the serotonin he can stop the mania. The drug to do this is Sansert, a serotonin antagonist. The Englishman and the Czechs gave 15 manic patients 6 mg. of Sansert per day—2 mg. less than we are permitted to use in this country for the prophylaxis of migraine. In 48 hrs. all 15 manics were asymptomatic. The drug was stopped, and the patients once again became fully symptomatic in 48 hrs. So if this theory holds up, we have another strong bit of evidence for serotonin involvement in mood disorders.

I should like to emphasize that all these modifications in the treatment of mood disorders are experimental. In this country if one doesn't have an IND exemption from the Food

and Drug Administration and uses those drugs as they were used in the experiments, he can get into a lot of trouble if something goes wrong. As you know, that requirement is one of the things which are slowing down clinical drug investigation in this country.

General practitioners, obstetricians and gynecologists, and psychiatrists nowadays are asking the question: "Do oral contraceptives cause a change in mood—specifically a depression?" Now all of the literature I have read on this topic—with a single exception—says things such as: "It seems possible," or "I wouldn't doubt it, though I can't prove it." When the author is a psychiatrist, he says he thinks the mental phenomenon may relate to the psychological significance of infertility, even if no more than transient. That sounds possible, and I have had such thoughts myself. Recently, however, two British obstetricians (not psychiatrists) reported on a study of 6,000 or 7,000 woman-years of oral-contraceptive use. As part of the study, 137 endometrial biopsies were done. Those British obstetricians believe the pill can and does cause depression accompanied by—and this is very important—a loss in sex drive.

Most psychiatrists agree that a reduction in sex drive always accompanies an endogenous depression. The two British doctors report depression *and* loss of sex drive in 28 per cent of women taking strongly progestational oral contraceptives. The incidence of depression on other types of oral contraceptives was reduced to only 6 per cent in women receiving the strongly estrogenic sequentials. Their report points to a relationship between the level of progestogen and the level of estrogen. The higher the level of progestogen and the lower the level of estrogen, the higher the incidence of depression. On the other hand, the lower the level of progestogen and the higher the level of estrogen, the lower the incidence of depression.

Before anyone begins to wonder why a psychiatrist should be rambling on about female hormones, let me get back to those 137 endometrial biopsies. They were assayed for monoamine oxidase. (We now are safely back in psychopharmacology.) Monoamine oxidase is the enzyme that is essential for the breakdown of cerebral amines. The biopsies showed that in the late secretory phase of menstrual periods of women not on the pill, endometrial levels of monoamine oxidase rise. But when these women start oral contraceptives, endometrial monoamine oxidase often rises high either at ovulation or earlier, in the proliferative phase, and the highest MAO levels in the proliferative phase were in women taking strongly progestational compounds—the ones with the highest incidence of depression.

All this is enough to warrant the speculation that the changes in endometrial monoamine oxidase enzyme, and the changes in mood and sex-drive might just be interrelated. Further, we can now speculate that hormonally-determined enzymatic changes just might be a common factor in the mood changes seen in premenstrual tension, postpartum depression, oral-contraceptive depression and involutional melancholia.

I'd like to finish by mentioning propranalol (Inderal). One can't pick up a medical journal nowadays without finding an article on Inderal, the beta-adrenergic blocker. At the Cleveland Clinic several doctors (including the sister of the dean of our College of Nursing) have been doing a long-term study with Inderal, and have discovered what they call the "hyperdynamic beta-adrenergic circulatory state." People who have it complain of palpitations, racing heart, chest discomfort, and acute and chronic awareness of what's going on underneath the sternum and ribs. Outside of Cleveland this symptom complex is called neurocirculatory asthenia, cardiac neurosis, effort syndrome, soldier's heart, or what have you. The Cleveland group say these symptoms—whatever their cause may be—are the manifestation of a hyperreactive condition of the beta-adrenergic receptors. When Inderal was used to treat patients with this state, it was found to be specific for the cardiovascular symptoms. Some people say Inderal also relieves the symptoms of central or free-floating neurotic anxiety. Others disagree, and our brief experience supports this negative opinion. But all the evidence is not yet in.

One thing done in Cleveland was very spectacular. Patients were given the beta-adrenergic drug Isuprel, and nine of the 14 patients developed "an uncontrollable hysteria." This state did not respond to a placebo, but it did respond immediately to Inderal.

From what I have read, I should imagine

that the Cleveland investigators believe they have identified a circulatory disorder that masquerades as a psychoneurosis. I wouldn't argue with them, but I suggest that this hyperdynamic beta-adrenergic circulatory state may also be a complication that prolongs and intensifies some anxiety neuroses that otherwise might be of limited duration.

In conclusion, the Psychotropic Drug Revolution in Psychiatry—a DeMille-like spectacle—has ended. Instead, psychopharmacology is entering a period which, if it fulfills its promise, just may put the treatment of many mental disorders on a fairly sound scientific basis, just as Koch's postulates proved the germ theory of disease and eventually helped medical treatment get onto a fairly sound scientific basis.

Dr. Clancy: I shall now call on Dr. Comly to comment on drugs used in treating the psychiatric disorders of children.

Dr. Comly: In last year's postgraduate course I reviewed the details of the hyperkinetic syndrome and the use of the mild cerebral stimulants dextroamphetamine and Ritalin. It is the hyperkinetic syndrome and some related cerebral dysfunctions that I believe are the children's difficulties most helped by medication.

The hyperkinetic reaction of childhood is a very common condition. A recently completed survey in St. Louis confirms my impression that it occurs in four or more per cent of the first-grade school population. Despite the fact that it has been recognized and written about since at least 1932, and that the effectiveness of stimulating medication was first publicized in 1937, I still occasionally see a child who has been given a sedative such as phenobarbital in an effort to control his overactivity, irritability and commonly coincident sleep disturbances. It seems the logical thing to do, but as you probably know, it quite frequently exaggerates the symptoms.

The commonest error I have noticed in the treatment of this group of children is that too large a dose is given initially. Also, physicians have the habit of directing the administration of medicine three times a day, and a dose of cerebral stimulant around supper time is apt unduly to interfere with sleep. I have therefore found it useful to begin with a smaller dose than the one that I think will be effective, and after three or four days to double the dose, and after another three or four days to add another 50 per cent. Let's take, for example, a seven- to nine-year-old hyperkinetic child. It is likely he will be well controlled with about 15 mg. of Ritalin or 7.5 to 10.0 mg. of Dexedrine, morning and noon. However it seems best to give 5 mg. of Ritalin morning and noon for two or three days, followed by 10 mg. for a few days, and finally 15 mg. morning and noon. The dosage of dextroamphetamine is roughly half the number of milligrams one would use of Ritalin. The dosage of Benzedrine is the same as that of Ritalin.

I think an interval of three days or so is advisable because the variations in the child's life are such as to make it difficult to establish a baseline and to make an adequate assessment of the drug's effectiveness, particularly when you are depending heavily upon inexperienced parents for your assessment. The classroom teacher is likely to be the best judge of the effects of the medication. Occasionally one finds a child who has a very positive and significant response from even the first dose, and as the dose is increased he may have some discomfort—some trouble sleeping, and a tendency to be tremulous or irritable.

Of course some children won't respond in the expected way to the stimulants. This should lead us to question the diagnosis, and perhaps consider referral to a more experienced clinician, but there certainly are some classically hyperkinetic children who do not respond well to the stimulants, and may be helped a great deal by chlorpromazine (Thorazine) or thioridazine (Mellaril). I personally prefer the latter because it less frequently produces the sun-sensitivity problem that we encounter with chlorpromazine. Again, I believe it is well to start with a relatively small dose, and it can be given at bedtime. After two or three days a larger dose can be given at bedtime, and one may begin to get evidence of improved control during the day, without the sleepiness that certainly can be bothersome to the school teacher. If the dose needs to be increased it can be given in the morning, but it should first be a dose about half of that given at bedtime. In the average school-age child some benefit is often found after the child has begun receiving from 20 to 50 mg. of Mellaril at bedtime and 10 to 25 mg. in the morning. The dose of Thorazine would be about the same number of milligrams given in the

same pattern, and would probably work just as well during the major part of the year when the child was not exposed much to the sun.

Another error that the busy physician all too frequently makes is that of spending insufficient time explaining the medication, its effects, the reasons for its use, how to tell whether it is helping, etc., to the parents. And of course some reasonable explanation must also be given to most child patients. It takes considerable time for the specialist to establish a therapeutic relationship, and there, of course, the family doctor may have a distinct advantage over the specialist. Certainly all drugs have a profound placebo effect. The placebo effect can also be a negative one, and I think sometimes the negative placebo effect definitely overshadows and outweighs a positive physiologically-determined medication effect. I think this occurs because we are too busy, sometimes, and take for granted that the parents accept the idea of medicines for their children.

The use of a drug to change a child's behavior and to help him in school carries big implications with it, and stirs up a great deal of worry in the parents. Hence, establishing a strong relationship with them and exhibiting a readiness to respond to their questions both at the conclusion of the explanation and later, by telephone, will greatly enhance the effectiveness of any medication program. Personally, I am surprised at how *infrequently* I am called when I have taken time to spell out clearly what is to be expected, how the medicine works, how long it probably will be needed, and what the side effects are, and when I give the parents my office and home telephone numbers and urge them to call any time to ask any questions that occur to them. I firmly believe the parent must know the name of the drug being used, too.

It seems that both the cerebral stimulants and the tranquilizers improve the function of the "servomechanism" in the older part of the nervous system. Children with developmental lags in the integration of the nervous system seem to have special difficulty in this area of their physiology. They are less able to withstand stress, and the drugs seem to enhance their capacity. Hyperkinetic children tend to have more trouble during certain seasons of the year. Halloween and Christmas are particularly difficult, for at those times the school atmosphere is apt to become more exciting—more like a party, and less like the work-a-day, sober learning situation that flighty children need if they are to do their best work. With experience, one learns that hyperkinetic children respond with increased symptoms to sudden changes in the home or in the school. A new baby, a new TV set, a new puppy, a substitute teacher, a new seatmate in the classroom may be the kind of stress that makes the drug seem no longer effective. Simply increasing the dosage of medication, under such circumstances, may not bring about the proper effect. Therefore one has to look both at what is going on in the child's life and at the dosage of the drug and whether or not it is being administered in the proper routine.

Question: What test would you advise for evaluating children who are placed on these drugs for a long period of time?

Answer: With the years of experience that we now have had in using the amphetamines and methylphenidate, we can safely say there is no reason to be concerned about a bone-marrow depletion, and if the child is given an adequate diet, even though he may lose a bit of weight, his growth—height and muscle volume—will be normal, and he will be less likely to have accidents. Hence, in that sense I think he is healthier. Chlorpromazine and thioradazine have now been used for so long and for so many children without serious effects that I no longer feel it necessary to recommend liver studies or blood counts on a routine basis. If a child develops a sore throat, he certainly should be examined carefully, and the examination probably should include a white blood cell count and a differential count if indicated.

Question: How long do the children need to take these drugs?

Answer: I prepare parents for the possibility that the hyperkinetic child may need the medication for several years. Often he can have vacations from the medicine during the summer, but need it for the school months.

Question: How do you know which drug to use for these children?

Answer: I think it is important for the

clinician to familiarize himself with relatively few drugs—get to know them as well as possible—and then if the expected response does not occur following administration of any of those drugs to a particular child, he should refer the youngster for more expert help.

Question: At what age may drugs not be effective?

Answer: The stimulants, in my experience, seem to be less frequently effective in infants and children up to four or five years of age. The infants and pre-school children may be more readily overstimulated by the amphetamines. I am therefore inclined to use a mild tranquilizer like Vistaril or Atarax in younger children, at first, to see whether it doesn't improve sleep, impulse control, mood, coordination and attention to the parents' directions. Of course I have seen even three- and four-year-old children helped by Ritalin, just as school-age children are.

When children reach their middle teens—often when they have reached their full stature —they seem not to need the medication, and they begin to respond to amphetamine or Ritalin rather more like the adult. The dose that had a calming and organizing effect upon them for several years begins making them uncomfortable.

Question: Do these children frequently have learning disabilities?

Answer: Children with cerebral dysfunction —and many of the hyperkinetic children seem to have subtle disturbances in their neurophysiology—are likely to have perceptual problems, lags in the establishment of dominance, tardiness in developing a readiness for reading, etc., and hence are especially likely to be the victims of parental "pushing."

Question: What about Tofranil for children of this sort?

Answer: I have had limited experience with it, but there have been recent case studies—one of them a series of 52 cases reported by Dr. Hans Huessy, of the University of Vermont—where Tofranil had a very beneficial effect upon hyperkinetic children. I have used it occasionally in children with enuresis, and have been only moderately impressed with its effects. It has been suggested that it be given at bedtime, and even thus it improves the hyperkinetic disturbance, and there is an improvement in alertness, attention control and fine motor-coordination control in the classroom.

Eighth Annual Orthopaedic and Rehabilitation Seminar

April 3 and 4, 1970
YOUNKER MEMORIAL REHABILITATION CENTER
Des Moines, Iowa

Friday, April 3, 1970

Polk County Easter Seal Treatment Center, 2920 30th Street

12:30 p.m.- 4:00 p.m. "Scoliosis and Milwaukee Brace Clinic"—conducted by Robert Winter, M.D., University of Minnesota Medical School, Minneapolis, John H. Kelley, M.D. and Sidney Robinow, M.D., Des Moines.

4:00 p.m. MEETING, IOWA ORTHOPAEDIC SOCIETY

Saturday, April 4, 1970

Ralph L. Jester Auditorium, Iowa Methodist School of Nursing, 1117 Pleasant Street

9:00 a.m.-10:00 a.m. "Compression Neuritis of the Ulnar Nerve"—Geoffrey Osborne, M.Ch., F.R.C.S., professor of orthopaedic surgery, University of Liverpool

10:00 a.m.-11:00 a.m. "Carpal Tunnel Syndrome—Clinical, Electrodiagnostic, and Therapeutic Aspects"—John Melvin, M.D., associate professor, Department of Physical Medicine & Rehabilitation, Ohio State University, Columbus

11:00 a.m.-12:00 noon "Fracture Bracing"—Augusto Sarmiento, M.D., professor and head, Orthopaedic Surgery & Rehabilitation, University of Miami School of Medicine, Miami, Florida

12:00 noon- 1:15 p.m. LUNCH—Ruth B. Jester Gymnasium

Afternoon Session—Auditorium, School of Nursing

1:15 p.m.- 2:15 p.m. "Scoliosis—Current Concepts and Results of Treatment for Idiopathic Scoliosis"—Dr. Winter

2:15 p.m.- 3:15 p.m. "Spinal Stenosis"—Dr. Osborne

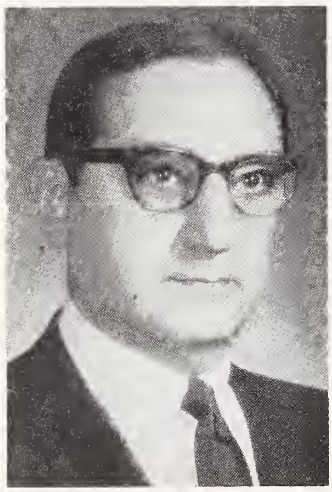
3:30 p.m.- 4:30 p.m. "Fractures of the Hand"—Adrian Flatt, M.D., professor of orthopaedic surgery, State University of Iowa College of Medicine, Iowa City

Discussion time will follow each lecture.

This program is approved for 6 elective credits by the American Academy of General Practice.

President's Page

Peer Review Must Be Done Only by Physicians



Peer review is the process by which the care rendered by a physician can be brought under objective scrutiny. It follows logically that if such an evaluation is to be an informed one, it must be performed by physicians, and by physicians only.

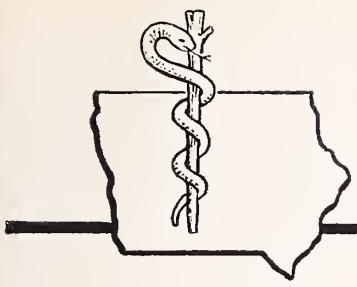
In these few words you have the philosophy of the Iowa Medical Society as it pertains to peer review. As recently as January 22, the IMS Executive Council reaffirmed this philosophy, and declared unequivocally that peer review should be solely a professional function.

It's reaffirmation was triggered by recent suggestions in the press that legislators and other laymen be considered for membership on peer review bodies. Lay understanding of peer review is encouraged; however, lay participation in the actual process is felt to be inappropriate.

We believe we have a responsibility to provide—and voluntarily—a sound and readily available peer review system. We are mindful that the profession must assure fair and judicious delivery of care. Peer review represents an important mechanism for assuring it. The Iowa physicians who have accepted peer review responsibilities are aware of the importance of their assignment. They are doing an admirable job.

Wm M. Kingston MD

President



Editorials

DIVERTICULOSIS AND DIVERTICULITIS OF THE COLON

Although one hears and reads of the frequency of diverticulosis and diverticulitis of the colon, the etiology and pathogenesis of those conditions seems to be poorly understood. A recent article by N. S. Painter, of Manor House Hospital, London, appears to offer a reasonable explanation.* At least it offers one that will give the patient some understanding of how his difficulty came about.

Painter found, in a study combining cineradiography and pressure recordings using open-ended tubes, that localized intracolonic pressures were generated by segmentation of the sigmoid. These pressures are created by contraction of the colonic muscle, and he showed that if the muscle is paralyzed by probanthine, the pressure within the lumen of the sigmoid falls to a basal level, and the localized segmental pressure is dissipated. According to Painter, "When segmented, the colon acts as a series of 'little bladders' whose outflow is obstructed at both ends, and in each segment or 'bladder' high pressures may develop. This mechanism is responsible for the pulsion force that causes diverticula to be extruded."

He points out that morphine, which is commonly used to relieve the pain in acute diverticulitis, increases the pressures in the sigmoid and should not be used.

The intermittent pain which occurs in the region of the left iliac fossa, and which comes and goes too rapidly to be attributable to an inflammatory process, is thought to be due to a functional obstruction caused by excessive segmentation. This condition has been called painful diverticular disease, to differentiate it from true inflammatory diverticulitis. In selected cases, sectioning of the sigmoid muscle, rather than resecting it, has been the procedure employed to relieve the pain.

To explain why the sigmoid is the site of diverticular disease, Painter postulates that feces are mixed in the cecum, then moved on to the descending colon, and then halted in the sigmoid. In this portion of the colon the feces are moved back and forth by segmentation until immediately before defecation, when they pass into and distend the rectum. If most of the feces were not held up in the sigmoid, the rectum would be filling continuously. This theory provides a reasonable explanation for the continence of feces. It is well known that when there is inflammation of the sigmoid or when there is ulcerative colitis, frequent defecation is a necessity.

Despite a reasonable understanding of the pathogenesis of diverticular disease, its etiology remains incompletely explained. It presents an increasing problem because of increased longevity, but it is also occurring with increased frequency in people who eat diets from which natural fiber has been removed during the milling of flour and the refining of sugar. It is uncommon among the native populations of underdeveloped countries, but it is frequently encountered in transplanted Europeans. The low-residue diet was blamed for the higher incidence in the latter group. Furthermore, experimental studies have demonstrated that a low-residue diet leads to diverticulosis in rats, and that a high-residue diet seems to protect them from it.

Painter submits the concept that it is perhaps the unnatural low-residue diet that alters the viscosity and the speed of transit of feces,

* Painter, N. S.: Diverticular disease of colon; disease of this century. LANCET, 2:586-588, (Sept. 13) 1969.

Editorials continued...

causing the sigmoid to segment excessively and to develop diverticulosis. He suggest that perhaps a return to a less sophisticated diet would achieve more than all of the surgical procedures, and would show that diverticular disease, like scurvy, is preventable.

TRENDS IN THE USE OF FORCEPS

A recent article by Ginberg, of the New York Polyclinic Medical School and Hospital, on trends in the use of forceps should be of unusual interests to all physicians concerned with the management of women in labor.* He has made a statistical study of the incidences of various types of forceps delivery at his institution over the past 25 years, subdivided into five-year study groups beginning with 1943-1947.

It is rather surprising to learn that there was very little difference between the percentages of forceps deliveries in the successive five-year periods. The figure was 55.8 per cent for 1943-1947, and it was 60.4 per cent for 1963-1967. In none of the quinary periods was it under 50 per cent. This occurred despite a procession of different attending men and resident physicians over the years.

Of unusual significance was a decrease in the use of low forceps during the last three five-year periods. In the years 1943 through 1947, low forceps were used in 57.9 per cent of all forceps deliveries. In the period 1963 to 1967, this percentage fell to 27.6. Low mid-forceps increased from 32.3 per cent during the first study period to 69.7 per cent during the last five years. This contrasted with a decline from 9.3 to 2.6 per cent in the use of mid-forceps. High forceps are no longer used.

The author points out that the incidence of cesarean section does not explain the changes in the use of forceps. The frequency of cesarean section varied very little during the five periods studied, and it was surprisingly high—a little over 8 per cent in each one.

He found it a bit difficult to account for the reduction in low forceps and the increase in mid-forceps. Though tempted to think it reflected a change in obstetrical philosophy, he acknowledged that there may have been a growing impatience in keeping with the increasing tempo of modern living. However the probable reasons are a greater awareness of the possibility of damage to the fetal brain and a tendency to shorten the second stage of labor by using forceps at a somewhat higher station. Advances in anesthesiology have permitted earlier intervention without increasing the hazard for the patient or the infant.

Ginberg found the decrease in the number of mid-forceps deliveries somewhat more difficult to explain. The Polyclinic group of obstetricians distinguish between two types of mid-forceps deliveries. The first includes those due to cephalopelvic disproportion, and they are the ones in which the mid-forceps operation should be abandoned in favor of cesarean delivery. The second group consists of those in whom the etiology is uterine inertia or faulty mechanism of labor. The latter challenges the diagnostic acumen and the skill and judgment of the physician. It is in such cases that vaginal delivery is the procedure of choice. Pitocin and the skillful use of forceps facilitate this type of delivery.

During the last two five-year periods induction of labor was done in 14.3 and 13.2 per cent of cases, respectively, in contrast with rates of 2.1 and 7.6 per cent, respectively, in the 1943-1947 and 1948-1952 periods.

The incidence of cesarean section for cephalopelvic disproportion in primary sections did not vary significantly during the various study periods. This type of delivery was done in approximately 40 per cent of patients in whom cephalopelvic disproportion was present, and that figure remained substantially unchanged throughout the 25 years of the study.

The use of intravenous Pitocin to stimulate

* Ginberg, B. L.: Trends in use of forceps. BULL. N. Y. ACAD. MED., 45:1114-1117, (Oct.) 1969.

labor increased sharply in the final 15 years. From 1963 through 1967 it was employed in 34 per cent of the 5,383 deliveries. It is pointed out that stimulation of labor in addition to the frequent use of roentgen pelvimetry to diagnose cephalopelvic disproportion explains the reduction in the number of mid-forceps deliveries. They constituted only 3 per cent of the total usage of forceps.

As a consequence of the changes in obstetrical practice, special types of forceps designed for limited but specific uses have for the most part been abandoned by the group at the Polyclinic Hospital. The most commonly employed forceps in use there is the Simpson—one of the recognized "bread and butter" instruments.

Dr. Ginberg concluded with the statement: "The use of intravenous Pitocin, both to induce and stimulate labor, combined with a cesarean incidence of 8.7 per cent, is offered as the explanation of the changes in the use of forceps." In discussing the findings in his study, he acknowledges that whether the changes in the use of forceps have been a mixed blessing can be debated. However he declares, "The fact remains that fewer mothers and babies suffer severe trauma as time goes by." Although the total interventions in natural birth processes are constantly increasing, their growing prevalence is justified by the improved results. He asserts that if the pendulum has swung too far toward a readiness to intervene, it will almost certainly return.

Apropos the changes in obstetric techniques, a report from Maternity Hospital, Dublin, relates the experience with 1,000 primigravidae there in efforts to avoid prolonged labor.† In this group, 204 (20.4 per cent) were treated in attempts to accelerate the progress of labor; 84 had artificial rupture of the membranes; 85 were given oxytocin intravenously only; and 35 of the group had both artificial rupture of the membranes and oxytocin. The authors report that their policy of controlled labor brought about a sharp reduction in the incidence of forceps delivery, from 30.3 per cent to 18.9 per cent over a period of two years. They assert that difficult cases of rotation and the application of high forceps are now rarely necessary. They attribute this change to the fact that the mothers now are not exhausted when they enter the second stage of labor, and effective contractions can thus be maintained until delivery. The incidence of cesarean section in this group was 4 per cent.

A somewhat more conservative approach to the management of prolonged labor has been advocated recently by Frederick J. Hofmeister, of Milwaukee.‡ He asserts that if the membranes are intact, amniotomy may be indicated. Ineffectual labors are frequently converted to productive ones very shortly after the membranes are ruptured. He states that no harm can be done if the presenting part is engaged and if the presentation is cephalic.

The Milwaukee obstetrician admonishes his readers, "Beware of the hazards, and recognize your responsibilities when oxytocics are used." He says that real dangers may exist both for the multigravida and the primigravida, and particularly for the elderly multigravida. Stimulation may result in rupture of the traumatized lower uterine segment, and tetanic contractions of the uterus may create serious hazards for the infant and may cause extensive injury to maternal tissues.

He urges intelligent observation and accurate care, and emphasizes the necessity for "an intelligent approach based on careful evaluation and (casting) aside antiquated methods of obstetrical procedure and obstetrical tricks for cesarean section." He also points out that sections are still associated with every hazard of major surgery, so it is important to exercise caution and to be guided by sound indications. He acknowledges that if cesarean sections are performed when indicated, the overall frequency of such procedures can, at times, rise beyond 5.0 or 5.5 per cent.

† O'Driscoll, K., Jackson, R. J. A., and Gallagher, J. T.: Prevention of prolonged labor. BRIT. MED. J., 2:477-480, (May 24) 1969.

‡ Hofmeister, F. J.: When labor is prolonged. WISCONSIN M. J., 68:203-205, (June) 1969.

1970
Iowa Medical Society
Annual Meeting
April 26-29

Editorials continued...

ARTERIAL HYPERTENSION: DIAGNOSIS AND TREATMENT

For all clinicians involved in the care of patients with hypertension, the proceedings of a conference of the New York Heart Association on the subject "Arterial Hypertension: Diagnosis and Treatment," held in January, 1969, should be of great interest.* That hypertension is a common problem is confirmed by the estimate that some 17,000,000 adults in this country are affected by it, and that by the time they reach 19 years of age at least 1 per cent of girls and 2 per cent of boys have hypertension as determined by blood-pressure readings alone.

Despite extensive investigation over a period of many years, the etiology and pathogenesis of most cases of hypertension are still unknown. Although the course of primary or essential hypertension in many instances is relatively benign, and patients with it may live for many years without experiencing significant interference with their way of life, it is well recognized that in general it does shorten the life span and lead to disability and death from coronary artery disease, hypertensive heart disease, stroke or other forms of vascular disease.

In contrast to essential hypertension, there are certain cases of secondary hypertension which are well understood and can be successfully treated. Dramatic results have been reported in patients with pheochromocytoma, unilateral renal vascular disease, aldosteronism and coarctation of the aorta.

Several of the presentations in the symposium were concerned with the controversial subject of antihypertensive therapy of essential hypertension, and they are especially thought-provoking. Dr. A. A. Brunt, of Cincinnati, emphasizes that it is extremely important to individualize treatment, and that if it is to succeed there must be an effective doctor-patient relationship, for changes in drugs and in dosage schedules are often necessitated by individual responses to medication. He urges that if the patient is obese, it is wise for him to lose weight. In the use of drugs, he recommends that progress should be made from the mildest to the most potent, starting with diuretics. He asserts that if one treats benign hypertension and begins with diuretic therapy as the background medication, perhaps 50 per cent of all hypertensive patients will require no more drugs. For many years it has been considered unwise to use a combination of drugs, such as reserpine and a diuretic, but Dr. Brunt states that this objection no longer seems to be tenable if the medications have been shown beneficial individually. Particular attention should be given to postural responses, and the blood pressure and pulse should be measured with the patient in three different positions during each visit. It is necessary to educate the patient fully concerning the side effects of the various drugs. Indeed this is an important part of the doctor-patient relationship, according to Dr. Brunt.

In concluding his discussion, he states that there is new and convincing evidence at certain of the ravages which high blood pressure produces can be prevented by available pharmacologic tools. However, whether or not these drugs which lower blood pressure retard arteriosclerosis to any extent is still a moot point. Perhaps another 10 years will resolve this question.

In a paper entitled "The Value of Antihypertensive Therapy," E. D. Fries, of Washington, D. C., concludes with the statement that the results of well-controlled clinical trials offer convincing evidence that all patients with diastolic blood pressure levels averaging 115 mm Hg or higher should have their blood pressures reduced. He says, "This is a high-risk group in which the value of antihypertensive drugs has been amply demonstrated. The risk is just as high in women as in men when the diastolic pressure is persistently elevated to these levels." He points out that it is in this group

* New York Heart Association Conference on Hypertension: Diagnosis and treatment. BULL. N. Y. ACAD. MED., 45:809-968, (Sept.) 1969.

of people with diastolic pressures of 110 to 120 mm Hg or higher that hypertensive" complications usually develop, such as an accelerated phase of the disease, congestive failure, strokes or dissecting aortic aneurysm. By contrast, those patients with diastolic pressures maintained above 90 but below 110 mm Hg usually progress more slowly to atherosclerotic complications, especially coronary-artery disease. Dr. Fries, like Dr. Brunt, states that it has not yet been demonstrated that antihypertensive drugs can retard the progress of accelerated atherosclerosis, which occurs in patients with all degrees of hypertension.

William Goldring, a professor of medicine at New York University, reviews the successive methods of therapy which have been employed since the turn of the century, each new approach introduced with enthusiasm, only to be rejected for another method which seemed to offer greater promise. He declares, "The prevention and cure of essential hypertension are as elusive as ever, and the possibility of clinical control of the disease is still on trial even though, in regard to control, general opinion is heavily in the affirmative."

He is skeptical and restrained in accepting blood pressure-lowering drugs as even a partial answer to the management of hypertensive disease. He asserts "After approximately 15 years of assorted data collecting, the alleged usefulness of antihypertensive drugs rests on conclusions drawn from notoriouly uncertain statistical compilations compounded by equally uncertain estimates of morbidity and mortality in the natural history of a disease of highly unpredictable course."

Dr. Goldring does not completely deny the possible clinical usefulness of antihypertensive agents, but he expresses serious concern that this era of empirical treatment of hypertension may prove to be one of uncontrolled clinical-pharmacologic experimentation, rather than one of lasting benefit to patients. He points out that his skepticism is based largely upon the fact that drug therapy can be pursued seriously only by those who believe that cardiac, cerebral, retinal and renal vascular diseases are direct consequences of elevated blood pressure. There are several alternative possibilities: Vascular disease and hypertension may arise from a common cause and may simply be different manifestations of the same disorder. Vascular disease may have an entirely different origin, and its association with hypertension may be coincidental. It is possible that vascular disease may precede and account for the hypertension. Or hypertension, arising independently, may accelerate the progress of a pre-existing vascular disease. Dr. Goldring asserts that inasmuch as it is impossible to establish the validity of any of these theories, it is hazardous to accept the critical basis for drug therapy without skepticism. He concludes by emphasizing the points that drug therapy is still on trial; that the etiology and pathogenesis have eluded two generations of investigators; and that new approaches to the problem are desperately needed.

The most valuable result of education is the ability to make yourself do the thing you have to do, when it ought to be done, whether you like it or not.

—Thomas Huxley

University Hospitals DRUG LETTER

Pentazocine

ROGER K. FERGUSON, M.D.

According to advertising claims, pentazocine (Talwin®) has found increasing favor among physicians and patients since its introduction two years ago. Marketed originally as a potent *non-narcotic* analgesic, it is not claimed to be such in more recent advertisements. Even the description "not subject to narcotic controls" lends itself to misconceptions about the drug. The purpose of this article is to review some of the pharmacologic properties of pentazocine that are pertinent to its clinical use.

Pentazocine was initially described as non-narcotic because it did not suppress the abstinence syndrome in persons physically dependent on morphine. That finding was interpreted by some to mean that it did not produce dependence. In fact this was never the case, since the early studies clearly showed that physical dependence did develop with prolonged administration of the drug. Abstinence signs, however, appeared milder and unlike those associated with withdrawal from morphine. Hence, the drug was not classified as a narcotic, and in addition, was thought to possess a low abuse potential. When these studies were extended, however, it became apparent that subjects exhibited drug-seeking behavior if the drug was withdrawn abruptly.[1] Extensive clinical use revealed that patients developed tolerance as well as dependence with chronic administration. In reported cases[2–4] this more often occurred when patients were allowed to self-administer the drug. Because of the tendency to increase both the amount and the frequency of injections, the physician should set limits on pentazocine's use. Under usual circumstances the development of dependence and tolerance should not be a problem. There are indications, however, that some persons will pilfer the drug if given the opportunity. Thus, despite the fact that stricter controls are not recommended at this time, the drug should be prescribed with many of the same precautions as are observed regarding other strong analgesics.

The usual parenteral dose recommended by the manufacturer is 30 mg. In a large group of postoperative patients[5] approximately this dose (28 mg.) produced a peak analgesic effect equivalent to 10 mg. of morphine. Because of pentazocine's somewhat faster onset and shorter duration of effect, however, the overall equianalgesic dose of pentazocine was closer to 40 mg. Of course smaller doses may suffice for lesser degrees of pain.

Pentazocine is also supplied in tablets for oral use, but is poorly absorbed from the gastrointestinal tract. It is only one-fourth to one-third as potent by the oral as by the parenteral route. One group[6] has found that peak plasma levels of pentazocine correlated well with its peak analgesic effect by all routes of administration. Table 1 summarizes the temporal characteristics of the analgesic effect of pentazocine by the various modes of administration. The plasma half-life was two hours after intramuscular or intravenous administration. The drug is extensively metabolized and excreted in the urine.[7]

Pentazocine produces side effects similar to those associated with narcotic analgesics. Adverse effects include nausea and vomiting, drowsiness, sweating and headache. Dizziness after pentazocine, however, is more marked than that following morphine, and is aggravated by standing up and walking. The drug also is reported to produce hallucinatory effects. Furthermore, subjective complaints of lassitude and asthenia may outlast detectable plasma levels of the drug.

The respiratory effect of pentazocine compared to that of the narcotic analgesics remains a disputed point. The manufacturer claims that pentazocine is relatively free from the severe respiratory depression associated with morphine. In normal subjects,[8, 9] on the other hand, 20 mg. of pentazocine produced rises in PCO_2 as large as those following 10 mg. of morphine. Moreover, the patterns of recovery were the same for the two drugs. A comparative study of the respiratory effects of equianalgesic doses of pentazocine and morphine or meperidine in patients with postoperative pain is needed. Meanwhile pentazocine should be used with the same caution as other narcotics in patients with severe respiratory disorders or respiratory depression from any cause. At the University of Iowa Hospitals, pentazocine has not been a useful supplement to nitrous oxide anesthesia, mainly because it does not depress the cough reflex as well as meperidine or morphine.[10]

Dr. Ferguson holds a clinical fellowship in the Department of Internal Medicine at the U. of I. College of Medicine. This article appeared initially in the November, 1969, issue of DRUG LETTER, a monthly intramural publication of University Hospitals, Iowa City. It is published here at the suggestion of the Clinical Pharmacology Committee at the University and with the permission of the author.

TABLE I

TIME COURSES OF THE ANALGESIC EFFECT OF PENTAZOCINE ADMINISTERED BY VARIOUS ROUTES[5]

Route	Onset of Effect	Peak Effect	Duration of Effect
Intramuscular ...	15-20 min.	30-60 min.	2-3 hrs.
Intravenous	3-5 min.	15-45 min.	1-2 hrs.
Oral*	45-90 min.	Variable: 1-3 hrs.	2-5 hrs.

* 75 mg. dose.

It seems reasonable to use pentazocine in situations in which dependence and tolerance are likely to develop from the administration of a narcotic drug. Although pentazocine does not suppress the abstinence syndrome in patients addicted to morphine, one must not assume that cross-tolerance to the analgesic effects does not exist. Indeed some patients who become tolerant to the pain-relieving effects of narcotic drugs also fail to respond even to large doses of pentazocine. Thus, pentazocine may not always be effective as a substitute if tolerance develops to the narcotic analgesics. In addition, since pentazocine is a mild narcotic antagonist, it may precipitate withdrawal symptoms when given to persons dependent on narcotics. Whether alternate administration of morphine and pentazocine would retard development of a dependence or tolerance to either remains to be determined.

Two recent reports[11, 12] have indicated that pentazocine has a therapeutic advantage over the narcotic analgesics for the treatment of pain in myocardial infarction. Additional studies are needed to substantiate those claims, however.

In summary, pentazocine has proven an effective drug for the relief of severe pain. The drug does have abuse potential, however, and should not be used indiscriminately, especially in persons who are prone to overusage of drugs. At the present time it possesses an advantage in that narcotic records are not required; however uncontrolled distribution could cause stricter controls to be applied.

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Postgraduate Course in Laryngology and Bronchoesophagology

April 6 through 17, 1970

The Department of Otolaryngology of the Eye and Ear Infirmary of the University of Illinois Hospital and the College of Medicine of the University of Illinois at the Medical Center, will conduct a postgraduate course in Laryngology and Bronchoesophagology from April 6 through 17, 1970. This course is limited to 15 physicians, and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, and diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Illinois 60680.

Coming Meetings

(Continued from page 82)

Mar. 13-20	**Paediatric Surgical Meeting**, Melbourne.
Mar. 17-20	**Canadian Association of Radiologists, 33rd Annual Meeting**, Montreal.
Mar. 19-21	**Association of Clinical Pathologists**, Edinburgh.
Mar. 30-Apr. 4	**Latin-American Congress of Obstetrics and Gynecology (6th)**, San Jose, Costa Rica.
Apr. 6-8	**European Congress of Perinatal Medicine**, London.
Apr. 11-17	**American Orthopaedic Association, Annual Meeting**, Melbourne, Australia.
Apr. 20-24	**17th Biennial Congress, International College of Surgeons**, Paris.
Apr. 26-30	**First International Congress on Group Medicine**, Winnipeg, Manitoba, Canada.

INFORMATION FROM THE
IOWA HEART ASSOCIATION

Recognition of Pulmonary Embolism

JAMES K. ALEXANDER, M.D.
HOUSTON, TEXAS

The diagnosis of acute pulmonary thromboembolism may be derived from history, symptoms, physical findings, electrocardiogram, serum enzymes, chest roentgenogram, pulmonary function tests, isotope lung scan, and pulmonary angiography. Of these, angiography is by far the most accurate and specific in detecting the presence and extent of embolic disease. Indeed, angiography may be absolutely necessary to establish the diagnosis in the presence of congestive heart failure, or to differentiate such conditions as atelectasis, pneumonia, acute myocardial infarction and peritonitis.

The symptoms of acute pulmonary embolism are notoriously protean, so that the disease may mimic a variety of neurologic, cardiovascular, respiratory, and upper abdominal disorders. Dyspnea, restlessness, and apprehension are common, as are symptoms due to cerebral ischemia such as dizziness, syncope, and convulsive phenomena. Dull substernal pain signals massive embolism, and is probably secondary to coronary insufficiency. If pulmonary infarction ensues, pleuritic pain, cough, and hemoptysis may develop. Wheezing occurs infrequently with acute pulmonary embolism, though atelectasis and hypocapnia in the affected regions of the lung favor airway narrowing.

Of the findings on examination, hyperpnea is the most consistent, and often the most striking. Though increased physiologic dead space is a factor, the mechanism of hyperpnea in man is unknown. Oxygen administration usually produces little effect. Fever, tachycardia, and tachypnea are frequent findings. Signs of venous thrombosis in the legs develop in less than half the patients, and may not appear until days or weeks after the onset of cardiorespiratory or neurologic symptoms. Jaundice is more often due to hepatic dysfunction than to hemolytic mechanisms, and it occurs most frequently in association with congestive heart failure or chronic liver disease.

Certain symptoms and signs in an appropriate clinical setting may strongly suggest the diagnosis of pulmonary embolism, but these same findings may obtain in other diseases. To establish the presence of acute pulmonary embolism, or to rule it out, additional diagnostic aids are almost always necessary. The conditions most frequently presenting differential diagnostic problems are pneumonia, atelectasis, pericarditis, cholecystitis, dissecting aortic aneurysm, cardiac tamponade, acute myocardial infarction and hyperventilation syndrome.

The appraisal of aids in diagnosis may begin with electrocardiography. In most cases, acute pulmonary embolism produces no definite electrocardiographic abnormality, and the transient nature of the changes, when they do occur, is characteristic. The electrocardiographic findings most commonly observed—namely sinus or supraventricular tachycardia, right axis deviation, right bundle branch block, and inverted T waves in leads V_1 to V_3 or V_4—may be helpful, but are all non-specific.

Elevated serum lactic dehydrogenase (LDH), along with normal serum glutamic oxaloacetic transaminase (SGOT) and normal or elevated serum bilirubin, favor the diagnosis of pulmonary embolism. However, LDH levels may not rise following embolism, and elevation is a nonspecific finding, since it occurs also with cardiac failure, shock, pregnancy, liver disease, and after surgical procedures. In addition, LDH assay does not differentiate pulmonary infarction from pneumonia.

Chest roentgenographic findings may be suggestive of embolism, but are not often diagnostic. Before frank infarction develops, the chest film may show no abnormality. In some cases, enlargement of main pulmonary arteries or their major branches is discernible, with absent or diminished pulmonary vascular markings peripherally. The hemi-diaphragm on the affected side may be elevated as a result of atelectatic changes. Pulmonary densities appearing after infarction are typically subpleural, may be transient, are often associated with effusion, and most frequently involve the right lower lobe.

Scintillation scanning of the lungs, after intravenous injection of macro-aggregated human serum albumin particles labeled with I^{131} or other appropriate radioactive material, is a useful technique in the diagnosis of acute pulmonary embolic disease. Since most of these particles have a larger cross-sectional area than the average pul-

Dr. Alexander is a professor of medicine at the Baylor College of Medicine.

monary capillary, they are trapped at the precapillary level during the initial transit through the lungs, and the distribution of radioactivity reflects regional pulmonary blood flow. Thus, segments to which the blood supply has been interrupted by occlusive thromboemboli will appear as "cold areas" or areas of diminished radioactivity on the lung scan. This method is advantageous because it is virtually without risk, and it lends itself well to the performance of serial observations. However, any condition leading to reduced or absent regional capillary perfusion may produce alterations in the lung scan, so that reduced radioactivity over the site of a pulmonary infiltrative lesion on the chest film can be anticipated regularly, and provides no differential diagnostic information. The diagnostic potential of the scanning procedure is greatest when embolism is suspected, but little or no abnormality is found on the chest film. Even under these conditions, "cold areas" may be found, particularly over lung bullae in obstructive lung disease, or over the lower lobes with left ventricular failure. Conversely, little abnormality in the scan may be seen in some cases where thromboemboli have produced partial but not completely occlusive lesions. Though cautious interpretation is required, the lung scan remains a very useful screening procedure in the diagnosis of acute pulmonary embolism, and once the diagnosis has been established, it may provide information regarding the course of the disease and the response to therapy.

Visualization of the pulmonary vasculature can be accomplished by either selective or venous angiography. In patients with acute pulmonary thromboembolism, the chief angiographic findings are complete or incomplete obstructions of various pulmonary arterial branches, intra-arterial filling defects, decrease in volume of affected lung segments, and changes in arterial caliber proximal or distal to the obstructive lesions. In other cardiorespiratory diseases such as cardiac failure, pneumonia, pulmonary tumor, abscess, bulla, fibrosis or emphysema, the pulmonary arteries may be compressed, displaced, or attenuated, but remain patent to the subsegmental level, showing neither filling defects nor obstructive lesions. Thus it is the identification of specific structural changes within the pulmonary arteries that renders angiography the most definitive diagnostic method available. The decision to perform arteriography ultimately must be a matter of clinical judgment, based on the status of the patient, facilities available, and possible therapeutic implications. Angiographic demonstration of pulmonary thromboembolism would appear essential before pulmonary embolectomy, and highly desirable before interruption of blood flow through the inferior vena cava.

Prescribing of Drugs in Thirty-Day Supplies

A Blue Cross-Blue Shield Informational Letter to Physicians

Numerous instances have come to the attention of the Carrier in which a large number of prescriptions have been written for a very small quantity of a single type of medication. In some cases as many as 15 different prescriptions for a single item of medication were dispensed by a pharmacy to one recipient in one month. The basis of payment for drugs dispensed by retail pharmacies is the acquisition cost of the drug plus a professional fee. This practice is a matter of serious concern to the [Social Services] Department, inasmuch as writing numerous prescriptions for small quantities of the same medication makes a professional fee chargeable for each prescription, and that in turn results in needless expense to the program. All providers of service are well aware that a shortage of funds has already made necessary one curtailment in the Medical Assistance program. Practices such as the one outlined above, if continued, could well make another necessary.

In order to control *unnecessary* expenditures, Dr. Elmer M. Smith, director of the Bureau of Medical Services, State Department of Social Welfare, with the advice and approval of the State Medical Advisory Committee, has directed the Carrier to release this Letter, *requesting the cooperation of physicians in prescribing a 30-day supply of medication, in all cases where it is not therapeutically contraindicated.* It is recognized that in some cases the nature of the medication or the condition of the patient may make it advisable for the physician to prescribe less than a 30-day supply. However, in most cases this is not necessary, and it is with respect to such cases that we are soliciting the cooperation of physicians.

Each retail pharmacy participating in the Medical Assistance program has also been informed of the Department's concern in this area. In the future, claims submitted by pharmacies will be reviewed in the office of the Carrier with reference to amount and frequency of medication prescribed. Cases in which a charge is made for two or more prescriptions for the same item of medication in one month will be subjected to a special review in the office of the Carrier, and payment to the pharmacy will be withheld, when indicated, pending receipt of written justification.

Date Effective. At once.

Additional Information. If any portion of this material is not clear please direct your inquiries to Blue Cross and Blue Shield, Carrier for the Iowa Department of Social Services.

STATE DEPARTMENT OF HEALTH

Homemaker-Health Aide Service Agencies in the Provision of Home Care Services

In the November and December, 1969, issues of the JOURNAL, we discussed the changes in public health nursing in Iowa, particularly the expansion of Home Health Services. In those articles we mentioned the development of Homemaker-Health Aide Services in recent years. This article will describe the development of this resource in more detail.

Homemaker-Health Aide Services provide assistance and support to professionals in both the health and social service fields. A comprehensive homemaker-health aide service may provide a wide variety of services to meet the different needs of those served. In general, the service is provided in a manner that will help the person served to be as self-sufficient as possible. The services can be generally divided into: (A) Personal and Special Services; and (B) Household Management. Any one individual could receive only one or many of the services indicated. A brief outline of what some of these services might include follows.

A. Personal and Special Services

Children may receive individualized personal attention such as bathing, preparation of infant formula, and dressing. Attention is given to health care including personal hygiene; preparation of special diets as requested by physician, nurse or dietitian; help in getting to medical or dental appointments; and in following advice. The homemaker-health aide may escort children to and from schools, playgrounds and clinics, as well as help with homework, story telling and reading.

Another service might be to help the children assume responsibility for themselves and for some of the necessary household chores. Many of the same kinds of services listed for children may also be provided to adults. Dependent, disabled or aging adults may require assistance in getting in or out of bed and to the toilet. They may also need supervision and assistance in carrying out the recommendations of their physicians, nurses, social workers, physical therapists, or nutritionists. The homemaker-health aide's role may be one of teaching and helping in personal adjustments, toward the goal of making the person as self-sufficient as possible. Thus, the homemaker-health aide is an integral part of the home-help team.

B. Household Management

The homemaker-health aide may help plan menus, buy food, and prepare and serve meals, which requires knowledge of nutrition, prices, cooking, and the appreciation of cultural patterns. The aide may help the family plan its expenditures and manage its funds, and sometimes actually pay its bills. Light cleaning and maintenance of the home may be required, but heavy cleaning should not be expected of the homemaker-health aide. Suggestions may be given regarding rearrangement of work areas and equipment so that the mother (particularly if she is handicapped) can better perform her duties. Sometimes the homemaker-health aide may be called on to buy clothing, as well as do light washing, ironing and mending. Assistance may be given to the inexperienced, immature and senile person in planning daily schedules and budgeting time.

The use of services provided by homemaker-health aide programs in the support of home health services in Iowa communities is becoming commonplace. Ten years ago there were no homemaker-health aide programs in Iowa. Now approximately half of Iowa's counties, containing 62 per cent of the state's population, are served by these programs, leaving 50 counties with slightly over ⅓ of our population, which have no organized programs.

In particular, Iowa's elderly, with their limited income, mobility, and access to helping resources, have been helped by these programs, for it is the elderly who are least able through personal efforts to obtain services of a type that these programs provide. Regular reports of programs to the State Council for Homemaker Services consistently reflect this use of services, with 75 per cent or more of their services devoted to the elderly. Failure to utilize the services of these programs for the contribution which they can make to the home care needs of others in the community is a shortcoming in many communities.

In addition to the referral of cases and the basic responsibility they have for individual cases, the health- and social-service professionals in the community serve formally or informally in an advisory capacity to the homemaker-health aide programs. The homemaker-health aides provide one component of care in the home care services of Medicare as described in the December JOURNAL. They also serve as an extension of nursing service in many non-Medicare situations, and as an extension of social service in other situations.

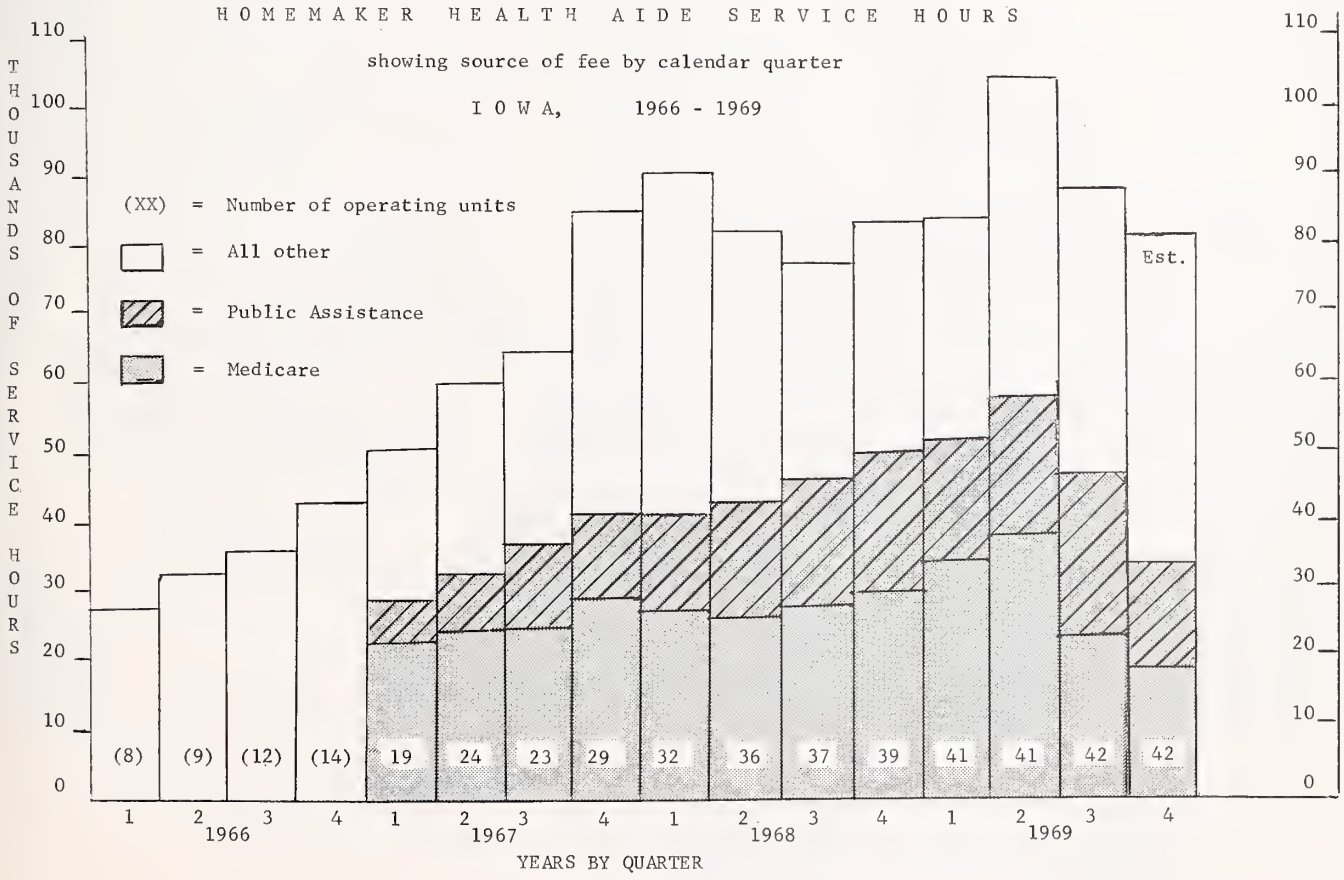
An important social principle is utilized as home-

maker-health aide linkages are established to a community's professional persons. This principle is that communication from professional sources, at times, can be most effectively accomplished if the communication seems to originate from someone who is considered a peer. This principle has been validated by many programs throughout the country that have used support personnel from the same social strata as the recipients, when communication was intended to move recipients to any intended action. All of this has exciting implications for homemaker-health aide *agencies,* as media through which *families* that are *hard to reach* with direct professional communications *can be motivated toward a desired action.* For example, a homemaker-health aide considered the peer of a family may, perhaps more effectively than a nurse, convince that family that she, the homemaker, considers it foolhardy to expose her own children to childhood diseases that can effectively be prevented by immunizations. The hard-to-reach families, in turn, accept and act upon this communication. This principle can apply to communication derived from other professional resources.

The commonest organizational pattern for homemaker-health aide agencies in Iowa is that of separate non-profit corporations. Others are subsidiaries of Family Service agencies, welfare departments, visiting nurse associations, or boards of health. The most important consideration regardless of what agency eventually sponsors the service, is that a group representative of a cross section of the community should guide the development and operation of the program. The group can decide where and how the program should be set up if it is to be acceptable and usable by the greatest number of people and of greatest service to the community.

An Interagency Committee of six state agencies—Commission on the Aging, Iowa State Department of Health, Iowa State Department of Public Instruction, Iowa State Department of Social Services, Iowa State Office of Economic Opportunity, and Iowa State University, Extension Service—has recently prepared a brochure entitled "Procedure for Developing a Homemaker-Health Aide Service in Iowa." Many physicians and county medical societies have been active in developing homemaker-health aide services in Iowa. These programs certainly need and deserve the understanding and support of all physicians.

Figure 1 indicates the growth in the number of homemaker-health aide agencies and in the amount of service provided in Iowa over the past four years. For most of the period it also indicates the amount of Medicare service and the amount paid for by public assistance. The decrease in the amount of service paid for by Medicare during the last six months of 1969 is very obvious. The tightening of restrictions which caused this decrease was discussed in the December issue of



the JOURNAL. This curtailment has also led to serious budget problems in many agencies. These, in turn, require the understanding and attention of community leaders, including physicians.

If you wish a copy of the brochure, please contact: Chronic Illness and Aging Service, Iowa State Department of Health.

Morbidity Report for Month of December, 1969

Diseases	Dec. 1969	1969 to Date	1968 to Date	Most December Cases Reported From These Counties
Brucellosis	4	41	32	Buena Vista, Jefferson Linn, Scott
Chickenpox	805	5,192	6,635	Black Hawk, Lee, Linn, Polk
Encephalitis				
California virus	1*	5	4	Clarke
German measles	148	2,534	2,049	Woodbury
Gonorrhea	418	4,360	3,991	Scattered
Hepatitis				
infectious	24	380	485	Appanoose, Delaware, Scott
serum	1*	4	1	Polk
Histoplasmosis	3*	22	33	Wapello—2, Woodbury —1
Impetigo	83	745	725	Black Hawk, Polk
Infectious				
Mononucleosis	38	528	441	Lee, Polk
Leptospirosis	5*	8	8	Jackson, Shelby, Webster —3
Malaria, imported				
P. vivax	3*	20	8	Johnson, Scott—2
Measles	22*	362	165	Shelby
Meningitis				
Echo 3	1	2	0	Polk
Meningo-				
encephalitis	1	7	4	Des Moines
Mumps	221	4,533	12,539	Jasper, Wapello
Pneumonia	69	605	356	Pottawattamie
Rabies in animals	12	103	126	Scattered
Rheumatic fever	3	34	27	Jasper—2, Crawford—1
Salmonellosis				
S. enteritidis	1	5	11	Appanoose
S. panama	2	12	2	Wapello
S. typhimurium	4	41	48	Black Hawk, Jasper, Polk, Pottawattamie
Shigellosis				
S. sonnei	13	121	53	Polk
Streptococcal				
infections	622	4,952	5,417	Johnson
Syphilis	65	742	726	Scattered
Tuberculosis	14	130	118	Scattered
Whooping cough	3	18	67	Carroll, Grundy, Pottawattamie

* Delayed

AMA Judicial Council Frowns on Physicians' Treating Close Relatives

The AMA Judicial Council recently issued the following statements regarding physicians' undertaking to treat members of their own families: "From time immemorial it has been considered unwise and improper for a physician to treat members of his immediate family for other than minor health problems or in emergencies. For him to do so would be in violation of Section 6 of the Principles of Medical Ethics and therefore unethical.

"Even if for some good reason it becomes necessary to treat a member of his immediate family, a physician should not charge, or make a claim for, or receive compensation for such service from the patient or from a third party payor on the patient's behalf."

Movie Designed to Recruit "Volunteer Physicians for Vietnam"

Despite the impressive success of the Volunteer Physicians for Viet Nam program, 400 more MD's are needed to meet the AMA's commitment to the U. S. Agency for International Development between now and June, 1971.

A recruiting film, "Bac Si My" (Vietnamese for "American physician") can be borrowed from AMA headquarters, in Chicago, for showings to county medical societies. It is 13 minutes in length and is in color.

Because it shows the activities of physicians serving a 60-day tour, it is also appropriate for former volunteers to show to groups of lay people whom they have been invited to address.

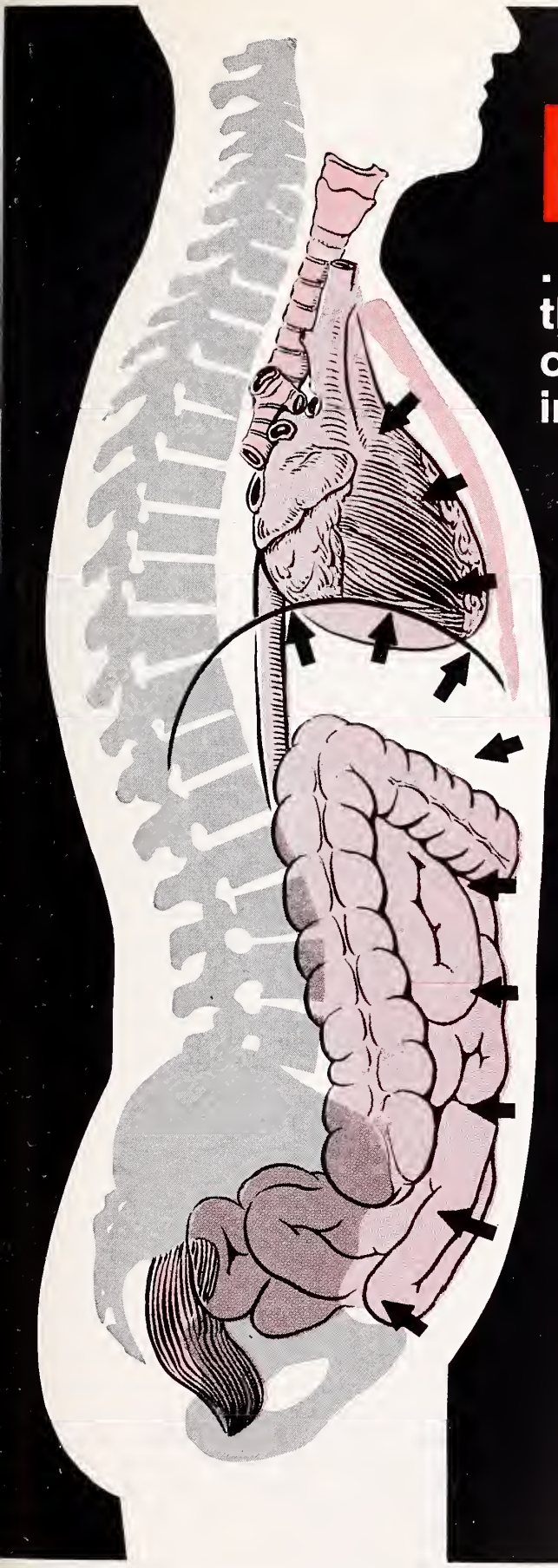
Prescribed for you—

1970

Iowa Medical Society

Annual Meeting

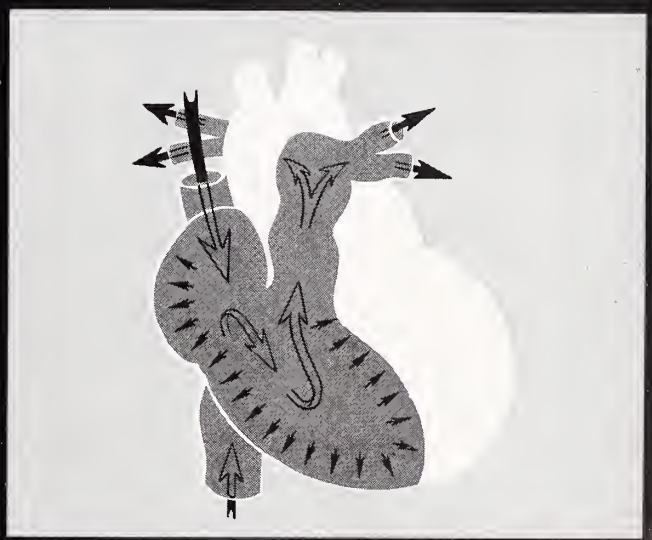
April 26-29



DOXIDAN®

...to reduce the hemodynamic "bind" of constipation in congestive heart failure

Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



Doxidan is a gentle laxative designed to free your patient from the hemodynamic consequences of straining at stool. With a fecal softening agent to keep the stool soft and easy to evacuate, and with just enough peristaltic stimulation to urge the sluggish bowel, Doxidan reduces the hemodynamic "bind" of constipation.

Composition: Each capsule contains 50 mg. danthron N.F. and 60 mg. dioctyl calcium sulfosuccinate.

Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice,* 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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C-12

Iowa Association of Medical Assistants

Calendars and Calendars!

While still in the throes of adjusting to a New Year and having completed the final quarterly returns for 1969, I wonder how many of you join me in wondering how the end of the year is decided upon, and what governs the beginning of the new year.

The Romans originally divided their year into three sections—Kalends, Nones, and Ides. Their year started with the spring moon in March, and ended about 300 days later in December. They disregarded the period between December and March, because "nothing happened" during those cold, dark 60 days. Sometimes faced with an extra month, they tucked it in between February and March, omitting five days from the end of February. By the year 47 B.C., January was arriving in the fall instead of winter due to this seasonal drift.

Ever since the first primitive man watched the sky and found that the moon went through an orderly progression of changes, men have been struggling to make a workable calendar. Unfortunately, each "month" is roughly 29½ days long (29 days, 12 hours, 44 minutes, and 3 seconds). Twelve of these lunar months add up to 354 days, leaving between 11 and 12 days short of a full year—the time that the earth takes for one revolution around the sun. The world runs on a regular series of unbroken rhythms and cycles, yet in the midst of all this regularity, man measures his own year by means of a complicated calendar. Our clocks tick off seconds, minutes, and hours with precision, but our calendar runs erratically. There may be four or five Sundays in any given month, and from 28 to 31 days. In a 365-day year there are 52⅐ weeks, and it is the "⅐" week that necessitates our months of various lengths.

The Aztecs used a solar "year-bundle" of 365 days, divided into 18 months of 20 days each. In consequence they had five empty days or "nemontemi," as they called them. The Egyptians turned to the sun as the central influence in time. Knowing the exact time of the month was important for them because they had to know in advance the date of the annual overflowing of the Nile which would make their soil fertile for the rest of the year. By using a combination of astronomy and mathematics, they discovered that the river's overflow came simultaneously with the yearly appearance of their brightest star, Sirius or the Dog Star. They operated on a 360 day schedule, and five extra days which were left over they added at the end of every year as a period of feasting.

Our current calendar is basically Pope Gregory's revision in 1582, which dropped three leap years out of each 400 years. This "future omission" didn't bother people, but dropping 10 days from the calendar for that year caused riots. England failed to make use of the Gregorian calendar until 1732,* by which time the English were 11 days behind. When it was decreed that September 2 was to be followed by September 14, the people were most incensed at losing 11 days so abruptly.

The calendar as we know today is not universal. In India more than 30 different calendars are in use. Currently several groups are working on calendar changes to produce a world calendar. Such a development would make every year the same and would offer standardized months and universal holidays. The plan is to start every year on Sunday, January 1, and have a Leap Year Day Quadrennial at the end of June. However, there still is an extra day to dispose of and it is proposed to end the year with a world-wide holiday, called "Worldsday." Should this be accomplished, "Worldsday" could be a big factor in uniting the people all over the world, for what brings us together more than something to celebrate!

And, since we are on the subject of calendars, be sure to mark yours for those big, important dates this year. The State of Iowa Convention, Waterloo, Iowa, May 15, 16, 17, and the American Association of Medical Assistants National Convention, Des Moines, Iowa, October 25-31, 1970. Detailed information will arrive at your offices, or you may write to Iowa Medical Assistants, c/o Iowa Medical Society at 1001 Grand Avenue, West Des Moines 50265. You need not be a member of AAMA to attend these conventions, and you can be certain your attendance will benefit both you and your employer.

—Jeanne D. Greene

* George Washington was born in that very year, on February 22, 1732 O.S. (old style), as it happened. Thus it has made extremely little sense for us to celebrate his birthday on February 22 N.S. (new style) all of these years.

THE DOCTOR'S BUSINESS



A Time to Take Stock of Your Practice

LARRY E. LEAVERTON
Des Moines

Recently when we asked an Iowa physician how things went for him in 1969, he replied that his number of patients seen and his gross income were about the same as they had been in the previous few years. He said he felt he couldn't see any more patients and was satisfied with his "stable" practice. What he did not realize was that his apparently stable practice was actually decreasing. To "stay even" in today's economy, a practice must *grow* by at least 6 per cent! In addition, a practice must *grow* to keep up with population increases and the increased demand for medical care.

At this time of year you are completing your financial information for 1969, and are consulting with your tax advisors to meet the federal tax deadline of April 15. Complete and accurate financial records are necessary for tax purposes, but they have additional utility. You can use some of the same information to evaluate your progress and make sound business decisions for the future.

The first question usually asked is "Where did it go?" If you are a typical Midwestern doctor, from each dollar of fees paid to you (gross income) about 40 cents went to operate your office; 15 cents went for federal income tax; 6 cents was spent for what we call "other deductions" (interest, taxes other than federal, and contributions to charities); 24 cents was spent for your own living expenses; 3 cents paid life-insurance premiums to protect your family; and the remaining 12 cents, you saved or invested.

Information accumulated for tax purposes can also assist you in determining: whether your overhead is out of line; whether your practice is growing; whether your facilities should be expanded to handle increased volume; whether hiring an additional office assistant is justified; and whether you should make other changes in the conduct of your practice.

Do you feel you have a successful and satisfying practice? People measure success in various ways. Some doctors confuse success with "busyness" and a full appointment book. In addition to being financially rewarding, your practice should be *personally* rewarding.

A PRIVATE PRACTITIONER'S CHECK LIST

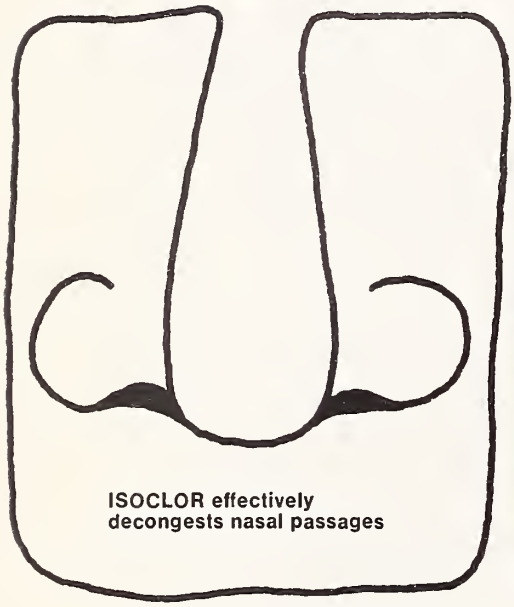
To determine whether you are successful both professionally and personally, you should be able to make emphatic affirmative answers to the following questions:

- Have you defined reasonable goals for the future? Do you know what you wish to accomplish?
- In the event of an unforeseen catastrophe, are your personal financial affairs in order?
- Are you building retirement funds for yourself, and an estate for the protection of your family?
- Are you serving your patients well, and for reasonable fees?
- How do you stack up as an administrator? Can your techniques be improved? Can your office be more efficient? Are you effective in managing and organizing your time?
- Is there anything more you could be delegating in order that you might have more time to devote to your patients' problems?
- Despite the fact that you are extremely busy, do you still find time to listen to your patients?
- Are you keeping up with your reading and are you attending meetings to keep abreast of your profession?
- Are you using patient-education material?
- Can your public relations and your human relations be improved during the coming year?
- Do you project the best possible image for yourself and for medicine as a profession?

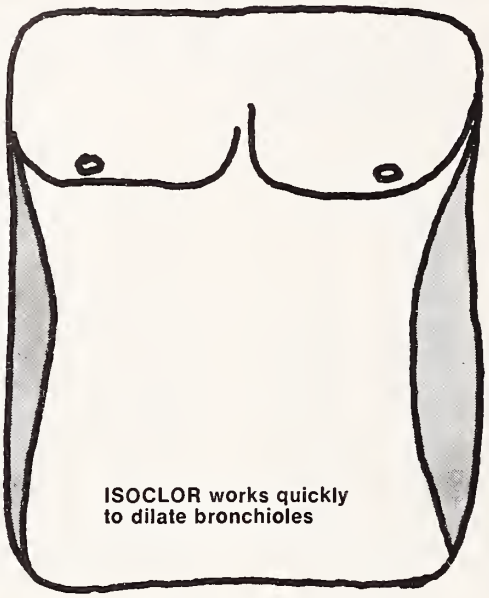
Honest answers to these questions could make 1970 a more successful and satisfying year for you.

Mr. Leaverton has been associated with Professional Management Midwest since 1949. He is a partner in the firm, and is director of its Research and Development Department.

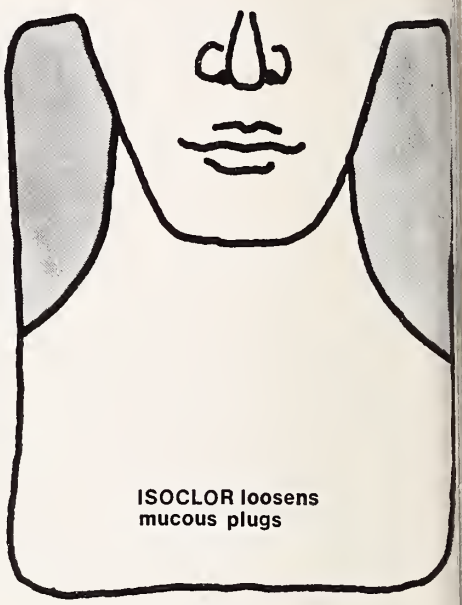
HERE ARE THE COLD FACTS:



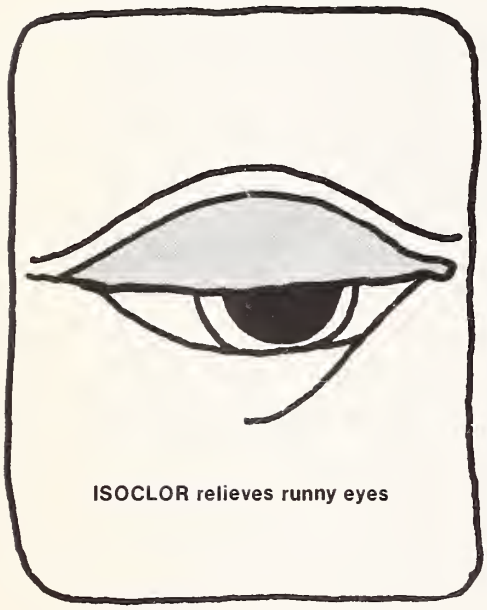
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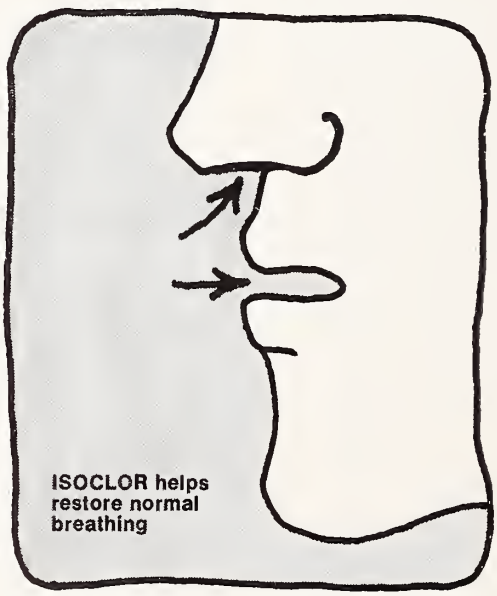
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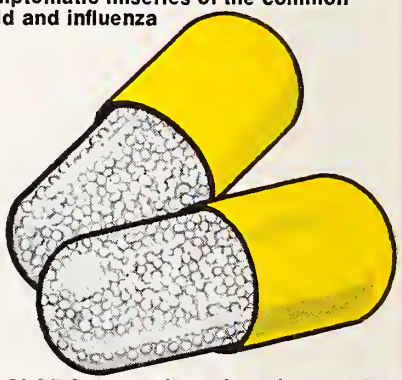


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COMPOSITION: Each tablet or 2 teaspoonfuls of liquid contains:
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Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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Woman's Auxiliary News

From the President's Desk

The Holiday whirl and the subzero temperatures have left your president in a somewhat suspended state of animation. However "time and tide wait for no man" or woman; hence we must get on at once with our program and with the arrangements for our upcoming Annual Meeting.

From present prospects it appears that this year's Annual Meeting will be loaded with worthwhile events for the membership. It is hoped that every member has given the Annual Meeting first place on her calendar. This year it is planned to allow more free time for spontaneous socializing and other unscheduled activities.

A highlight for the coming meeting is the fact that Mrs. John Chenault, of Alabama, our National Auxiliary President will be with us. It has been my pleasure to hear Mrs. Chenault speak, and I am sure her presence and her presentation will add immeasurably to the success of the meeting.

While perusing the AMERICAN MEDICAL NEWS I noticed an announcement of the American Medical Association's 23rd National Conference on Rural Health. It occurs to me that rural health would make a fitting theme for our Auxiliary in some future year. After all, Iowa is a rural state, and rural health is and should be a vital subject for all of us. Basically, although everyone is greatly interested in some of the marvelous new medical accomplishments of the day, we nonetheless should strive for the day when every Iowan has excellent medical care readily available to him for the usual and ordinary illnesses and accidents. The Iowa Medical Society and the University of Iowa College of Medicine are exerting every effort to man Iowa, medically.

May you have a happy Valentine's Day.

—JEANNE COUGHLAN (MRS. D. W.)

Have you moved in the past few months? PLEASE send any changes of address to 1001 Grand Avenue, West Des Moines, Iowa 50265. Communication is a necessity: Do help keep our mailing list up to date. You are our best source of accurate information.

Legislation Report

By the time you read this, the State Legislature will have been in session for some time. Hopefully, then, you will already have developed the habit of switching your radio dial to WOI at 9 o'clock each morning to listen to the live broadcast from the floor of the House or Senate. Iowa is unique in that its citizens are privileged to hear such broadcasts of their Legislature. The more often you listen, the more your interest and understanding will grow, and you *may* become as addicted to this "show" as some other women are to their T.V. soap operas!

The IMS Legislation Committee has been actively anticipating this session for some time. In the December AUXILIARY NEWS you were given the first I_1 (*"I shall be Informed"*) *Capsule* on the Professional Corporation Act and the reasons why it is supported by the IMS. Last month the *Capsule* concerned reasons for opposing the *Chiropractic Bill* (SF 91). Auxiliary members may be asked to help if this bill comes out of committee to the floor of the Senate for passage. The Iowa Heart Association recently stated its opposition to this bill, joining with such organizations as the National Council of Senior Citizens, the Iowa Arthritis Foundation, and the Health Planning Council of Iowa. Add the report on Chiropractic by HEW, and one finds that there is considerable substantiation by other groups for the IMS stand opposing this bill.

Your I_1 *Capsule* this month concerns both the *State Crime Laboratory* and *Opticians:*

State Crime Laboratory

This legislation has been passed by the Senate and is in the House Committee. It would establish a State Crime Laboratory under the direction of a state medical examiner within the University of Iowa College of Medicine. The Iowa Medical Society favors this type of legislation, and is supporting an amendment which clarifies the point that the state crime laboratory is to be under the direction of the state medical examiner.

Opticians

This legislation (HF 342; SF 288) would provide for the registration of dispensing opticians and would vest responsibility in the State Board of Medical Examiners for carrying out and ad-

ministering the law. The measure is strongly supported by the Iowa Medical Society in accordance with actions of the House of Delegates.

This bill makes it clear that dispensing opticians are empowered to fill physicians' prescriptions for contact lenses. After the legislation was introduced, the Iowa Optometric Association brought suit against a firm of opticians to enjoin it from fitting contact lenses. The bill would provide suitable safeguards to protect the public, and it would confirm the existing pattern of practice whereby physicians furnish prescriptions to patients for contact lenses.

The legislation is still in House and Senate Committees, and should be reported out and enacted. Otherwise there is a risk that ophthalmologists will be compelled personally to fit and dispense contact lenses, or to have this work done by technicians in their offices. This would seriously affect this area of medical practice and would tend to give optometrists a monopoly in the contact lens field, inasmuch as they customarily do their own refracting, fitting and dispensing in their offices.

—MRS. JOHN M. SCHUTTER

Pending Legislation

Many other items of legislation are of interest to the Medical Society and questions on specific bills should be directed to the headquarters office at 1001 Grand Avenue, West Des Moines, Iowa 50265.

Other items of legislation which will demand the attention of the Committee on Legislation are as follows:

1. *SF 269 Radiation Control*
2. *HF 402 Ambulance Licensing* (The IMS has approved guidelines which any state legislation must meet if it is to receive its approval.)
3. *HF 199 Vital Statistics*
4. *SF 386 Renal Disease Program* (Same as HF 656)
5. *SF 456 Nursing Home Administrators*
6. *HF 623 Hearing Aid Dealers* (Same as SF 550) (The concept of bringing paramedical groups under the Board of Medical Examiners whenever registration or licensure is requested is strongly recommended by the IMS Committee on Legislation. This, of course, is only an alternative to the basic position of the Medical Society supporting voluntary registration but opposing mandatory licensure of paramedical groups.)
7. *SF 265 Blue Cross-Blue Shield Tax* (Same as HF 481)
8. *HF 221 Make Blue Cross-Blue Shield a Mutual Insurance Company*
9. *HF 411 Hospital Service Discounts*
10. *SF 318 Physical Therapy* (Direct Supervision)
11. *Amendment to SF 77 regarding Temporary Licenses for Physicians*
12. *HF 610 Remove Mandatory Requirement That There Be a Title XIX Carrier*

Around the Hawkeye State

Boone County

Boone County Medical Auxiliary met in November for a one o'clock luncheon at the Imperial Inn Restaurant in Boone. Mrs. Ralph L. Wicks presided at the ensuing business meeting.

Mrs. Wallace Longworth, long a member of Boone County Auxiliary but now residing in Ames, presented an informative program on current state legislation of specific interest to Auxiliary members. Following the legislative program, the members spent the rest of the afternoon rolling bandages for the Iowa Partners of the Alliance. The Boone County Auxiliary has also donated hospital gowns for a charity hospital in Merida in conjunction with that program.

Buchanan County

The Auxiliary to the Buchanan County Medical Society entertained a number of students from area high schools interested in health careers after graduation at a tea at Hotel Pinicon, at Independence, in November. Seven persons in health career occupations explained the opportunities in their fields. The careers represented were nurse anesthetist, accredited record technician, registered occupational therapist; x-ray technician, registered nurse, laboratory technician, and dental assistant. A question-and-answer period followed the careers presentation.

In December the Auxiliary members were busy preparing for the annual county-home party, and the holiday meals for children at the local school for the retarded.

A silent auction was also on the agenda for the December meeting.

As in previous years, the Auxiliary joins in community projects by working with the Community Council and donating to the local Youth Center and Summer Playground Project.

Another program planned for the near future is one at which the public-health nurse will speak on helping and visiting the aged in the community.

Clinton County

The Clinton County Medical Auxiliary held its annual Charity Ball at the Clinton Country Club on Saturday, December 6. The theme for the ball this year was "Christmas Everywhere."

The proceeds were given to the medical staffs of the three Clinton County hospitals to help buy equipment necessary for the care of patients.

The Clinton County Auxiliary officers are: Mrs. A. L. Jensen, president; Mrs. G. D. Aurand, vice-president; Mrs. W. R. Meyer, secretary; and Mrs. D. H. Weber, treasurer.

Polk County

Net results from the annual Polk County Woman's Auxiliary "Holiday Greeting Card" project were most gratifying. Distributions have been made as follows:

AMA-ERF	$ 807.17
Camp Sunnyside (Campship)	97.50
YWCA (Balance on ramp)	427.50
WASAMA (Iowa City)	10.00
County Board of Education (Hearing and Amplification)	200.00
Meals Service	72.17
	$1,614.34

The Polk County Woman's Auxiliary has contributed $75.00 to the Iowa Society for the Prevention of Blindness, to be used in the vision screening program for public school children, in which its Auxiliary members participate.

The Auxiliary met for luncheon at the National Motor Inn, Des Moines, on November 14. Mr. Robert Harper, executive vice-president of the American Republic Insurance Company, spoke on "Crime in the Business Community." The business meeting was conducted by the Auxiliary president, Mrs. Floyd M. Burgeson.

Meet Our Members

Betty Schutter (Mrs. John M.), of Algona, a member-at-large, is serving as the State Auxiliary Legislative Chairman.

John and Betty, married during his internship in Phoenix, are the parents of five. Their family: John, Jr., physics teacher and swimming coach; Meg, a senior at University of Iowa; Jim, a junior at St. Olaf's; Steve and Anne, a junior and a sophomore at Algona High.

Betty was born in Illinois, and graduated from University of Iowa with a major in speech pathology. She taught for one year at the South Dakota School for the Deaf, at Sioux Falls, and presently does private clinical speech therapy.

Her current "card carryings" include memberships in A.A.U.W., Hospital Auxiliary, Historical Society, LWV, Woman's Auxiliary to the IMS and AMA, etc. She is also active at several levels in the United Methodist Church, is serving as Student-Family liaison for A.F.S. and has helped organize Girl Scouts in Algona.

Betty is active in the Republican Party and says she is sure her interest in politics must stem from her vote for Charles Percy for Senior Class President at New Trier (Illinois) High School because he won!

She urges everyone to support the party of his or her choice. She would have you and me get to know our legislators over a cup of coffee. While it may be hard to do this in larger towns and cities, Betty says, "If you don't know them how can you tell them our concerns?"

—MARY SMITH (MRS. RODGER B.)

Meet the Legislative Ladies

Included with your WOMAN'S AUXILIARY NEWS in January was a very important, *personal* invitation for *you* to attend the February 10 continental breakfast your Auxiliary is having for all the wives of our state senators, representatives, and other elected officials at the state level. Not only will you have the opportunity personally to act as hostess for the ones of these ladies who are from your district, but you will hear an interesting talk by the IMS president-elect, Dr. J. H. Sunderbruch. Plans have been made for you to visit the state capitol in the afternoon to watch the Legislature in action, if you desire.

Please consider participating in this Auxiliary function on Tuesday, February 10, for we are certain you will find the occasion both enjoyable and worthwhile.

Volunteer Health Service Award

If your county Auxiliary has selected a candidate for this year's "Volunteer Health Service Award" be sure the headquarters office is notified of your candidate by April 1.

The award is given annually to a person who has contributed an outstanding number of volunteer hours in the field of health, mental health or health education. The nominee is not to be a member of a physician's family or a professional health worker. The recipient of the award is chosen by the Iowa Medical Society's Advisory Committee to the Woman's Auxiliary.

If your candidate for the award has not been selected, it is not too late. Do so immediately, for your nomination, together with a brief description of her personal participation in the health field must be in the hands of the Advisory Committee by April 1. Forward to the Committee, c/o Woman's Auxiliary to the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, 50265.

More People to People

"Aloha" the delightful Hawaiian word with such a variety of meanings—hello, welcome, good fellowship, love, friendship, farewell—marked both the start and the end of our vacation this year. Hawaii is dear to our hearts, and a spot where we hope to return again and again.

The International Radiological Convention was held in Tokyo, Japan, and it was the impetus for the plans which we began making about a year ago. We had the pleasure of renewing friendships originated in South America two years ago, and it was our nucleus of friends that made this year's trip such fun. Our Japanese tour began in Kyoto, the old cultural center of the country, and Nara, the city of temples including the largest wooden structure in the world, Horyuji, and Todaiji, the Great Buddha. Japan has a mixture of Buddhism and Shintoism, one of which helps you prepare for the next world and the other encourages you to enjoy the "now." We were told that the young people are embracing both "Isms." Japan is a very clean country—the whitest white and the blackest black ever. Everyone is pleasant and courteous, and all facilities are crowded to the doors. The meetings were good, and the women's activities pleasant and informative. I especially enjoyed a doll-making experience, and brought the doll back for my little granddaughter. The best shopping, in my opinion, includes pearls and electronics.

Our next stop was Taipei, Formosa, the most pro-American country we visited. We also had the best guide there, a college graduate with excellent public relations and a charming manner. We missed the "Double Ten" holiday, but were able to enjoy many of the decorations which were still in place. At the Confucius Shrine—the image was brought from the mainland between 1945-1950, while it was still possible to get valuable objects out of the country—the inscription was translated for us: "There is no social class in education." It is believed to date back to the seven hundreds B.C. The National Chung Shan Palace Museum is most interesting, with great treasures of porcelain, ivory and wood from the various Chinese dynasties. Shopping there, one finds many handmade articles but they do not have the fine finish she sees in Japan.

Hong Kong is, without a doubt, the shopping center of the world. One just can't imagine the tremendous variety and quantity of goods offered to shoppers from all over the world. It is also a city of spectacular views from both sides of the bay. As one looks across the Victoria Point from a high vantage point on Kowloon at sundown and watches the island gradually light up, the sight is truly magnificent. Many think it is the most spectacular landscape in the world, and it surely ranks with such other beautiful spots as the harbor of Rio, in Brazil, or our own San Francisco. One can buy anything he wishes there, and in most any quality he wants to pay for, as well as in any quantity. One can now purchase up to $100 worth of items originating in Communist China—a new ruling in 1969.

In Bangkok, the Venice of the Far East, the canals are called Klongs. The traffic jams on them are just as great as the traffic jams on the freeways in and near Los Angeles. We were amazed at the canal system—though some of them are being closed—where the natives bathe, and wash their clothes, dishes and food—as well as come and go in boats. The most spectacular entertainment of our entire trip was the Classical Thai Dancers, beautiful and talented, and rated "G."

We relaxed in Honolulu for three days before returning to Iowa. I hope that I have whetted your appetites for one of these Oriental spots, and if so I hope you will include one or two others. "Aloha!"

—FRANCES HINES (MRS. RALPH E.)

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President-Elect—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501
Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312
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Cough Suppressant		●	●		●
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—SPRING TONIC FOR IMS MEMBERS—

1970 ANNUAL MEETING IOWA MEDICAL SOCIETY

- *Monday, April 27: Clinical Problems Confronting the Physician*
- *Tuesday, April 28: Survival on Earth, in Space, Under Water*
- *Exhibits / Luncheon Sessions / President's Reception / Medical Alumni Reunion Annual Banquet / Specialty Group Dinners*

— APRIL 26 to 29 — DES MOINES, IOWA

—MARK YOUR CALENDAR • PLAN TO ATTEND—



Personals



Dr. Najed Charaani began practicing surgery at Shenandoah the first of the year, and expects to be joined, shortly, by an orthopedist. He is a graduate of the University of St. Joseph (French Faculty of Medicine), he interned at St. John's Hospital, Long Island, New York, and took his residency in general surgery at New York Polyclinic Medical School and Hospital, and then took a two-year residency in thoracic and cardiovascular surgery at Emory University Hospital, Atlanta, Georgia. Immediately before coming to Shenandoah he was chief surgeon at a 250-bed hospital in Beirut and a 70-bed hospital in Tripoli, Lebanon. **Dr. Kein Gandour,** the orthopedic surgeon, is awaiting only a visa formality before coming to Shenandoah. He also is a native of Lebanon, and he has spent six years as an intern and resident in this country.

At one of the six two-day workshops on medical problems of the aged being sponsored by the Iowa Heart Association and the State Department of Social Services—the one held at the Mental Health Institute in Cherokee on December 4 and 5—**Dr. John Bakody,** of Des Moines, neurological consultant to the Capital Stroke Project, is reported to have said that 54 per cent of the American people are afflicted with diseases of the circulatory system, as well as that heart disease is the major cause of disability and death in the nation.

Dr. Donald E. Tyler is the new president of the medical staff at Mercy Hospital, Fort Dodge, succeeding **Dr. Maurice Kraushaar. Dr. James Habermann** is the president-elect; **Dr. James Reed** is the vice-president; and **Dr. William Jones** is the secretary.

Dr. Ben Bagon, Jr., a graduate of the medical school at the University of Santo Tomas, in the Philippines, who has had surgical training at St. Mary's Hospital, Huntington, West Virginia, and the Kaiser Foundation Hospital, Portland, Oregon, has announced his intention of practicing surgery in Algona. He and his wife, whom he met in West Virginia, have two sons three and one years of age.

Dr. Gerald Johnson, a staff member at the Cherokee Mental Health Institute, addressed members of the student body and other persons at Westmar College, LeMars, on December 10. His topics included: "What Does and What May Happen as the Result of the Use of Drugs," "Rational and Irrational Fears," "Why People Use and Misuse Drugs," and "The Controversy over the Use of 'Pot' or Marijuana."

At St. Luke's Methodist Hospital, Cedar Rapids, the newly-installed president of the 184-member medical staff is **Dr. David Thaler.** The president-elect is **Dr. Richard L. Sedlacek;** the vice-president, **Dr. Carl B. Lake;** and the secretary-treasurer, **Dr. John F. Troxel.**

The DES MOINES SUNDAY REGISTER for December 7 carried a feature story about a large old house at Lowell that **Dr. William H. Megorden,** of Mount Pleasant, bought about 15 years ago and has filled with antiques. The article mentioned an exceptionally large Chickering piano, the inside of which is gold-plated, and a player piano, both in working condition. Dr. Megorden, it was said, once owned a small antique shop in northern Iowa. He and his family occupy the house on weekends.

Dr. John H. Sunderbruch, of Davenport, president-elect of the Iowa Medical Society, and **Dr. Vera French,** a Davenport psychiatrist, were two of the physicians who participated in a conference, December 8, that laid plans for the formation of a bi-state metropolitan comprehensive health-planning program to serve the Quad Cities. The project is difficult, bureaucratically, because the Mississippi River constitutes the boundary line between two Midwest regions. About 85 people attended the meeting.

A locally-originated medical-film service is being set up in southwest Iowa with the encouragement of the Iowa Regional Medical Program based in Iowa City. A library of single-concept films will provide physicians an opportunity to study new developments in managing a wide range of medical and surgical problems, at their convenience. The counties to be served are Adams, Clarke, Montgomery, Page, Taylor, Union, and probably Adair, Decatur and Ringgold. The subcommittee appointed to oversee initial planning of the project includes **Dr. Fred A. Hansen** and **Dr. Jack D. Fickel**, of Red Oak; **Dr. Robert H. Kuhl**, of Creston; and a Greenfield osteopath. They are to review lists of available films from which a nucleus library can be set up to test response in the pilot area.

Dr. Madelene Donnelly Healy, until recently director of the Division of Maternal and Child Health in the State Department of Health, received two awards when the Iowa Obstetrical and Gynecological Society held its fall meeting in Iowa City. One of them was from that Society, and the other was from the U. of I. Department of Obstetrics and Gynecology. The former was a plaque; the latter, a medallion.

Dr. M. R. Moles was elected president of the medical staff at Skiff Memorial Hospital, Newton, on December 8. The other officers chosen were **Dr. H. A. VonHofwegen**, vice-president, and **Dr. L. D. Norris**, secretary-treasurer.

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Dr. Lawrence L. Marshall, of Jefferson, completed teaching a course in the care of coronary patients to 15 full- or part-time nurses at the Greene County Hospital, late in January. **Drs. Robert W. Burke** and **E. D. Thompson** are conducting a year-long course for surgical technicians at the same institution. It is designed to teach the tasks regularly assigned to non-professional personnel in the operating room.

With a year remaining of his present term, **Dr. F. L. Klingle, Jr.**, resigned from the Howard-Winneshiek Community School Board, late in November, saying his reasons were personal. Dr. Klingle, who practices in Cresco, was first elected in 1964 and was reelected in 1967.

Dr. Ronald R. Roth, of Waterloo, has been named clinician at the recently opened tuberculosis outpatient clinic at St. Francis Hospital, there. He succeeds **Dr. Elizabeth Procter**, of the State Department of Health, Des Moines, who had been acting clinician. The clinic, established in October, provides free diagnosis, evaluation and treatment for tuberculosis patients in 11 northeastern Iowa counties—Black Hawk, Buchanan, Delaware, Dubuque, Clayton, Fayette, Winneshiek, Bremer, Allamakee, Howard and Chickasaw. In addition, the clinic provides consultation service to private physicians on request.

Open house was held at the Bushmer Art Center, at Northwestern College, Orange City, on December 9. The building and three adjoining lots are a gift to the College from **Dr. and Mrs. Alexander Bushmer**, of Orange City. The Bushmers were present to receive the guests.

Dr. Walter A. Anneberg was reelected president of the medical staff at St. Anthony Hospital, Carroll, December 16. **Dr. Charles Fangman** was elected vice-president, and **Dr. John Hornberger**, secretary-treasurer. Dr. Hornberger practices in Manning, and the other two men in Carroll.

At the Floyd Valley Hospital, in LeMars, **Dr. L. C. O'Toole** has succeeded **Dr. D. K. Faber** as chief of staff. **Dr. L. A. George** was named vice-president, and **Dr. S. E. Lindell** was reelected secretary-treasurer. Dr. George practices in Rem-

sen, and the others in LeMars. **Dr. E. B. Grossmann, Jr.**, an Orange City surgeon, and **Dr. Paul Boone**, a Paullina general practitioner, were given staff memberships.

Dr. E. C. O'Connor, of New Hampton, will head the medical staff at St. Joseph Community Hospital there, during 1970, succeeding **Dr. Dennis Olsen. Dr. James C. Carr** is the new vice-president. **Dr. C. W. Rainy**, of Elma, was chosen as secretary-treasurer.

It was announced on December 18 that **Dr. Hormoz Rassekh** had succeeded **Dr. James Knott** as president of the Jennie Edmundson Hospital staff. **Dr. Raymond G. McDonald** had been chosen as president-elect, and **Dr. Morton H. Kulesh** as secretary-treasurer. The latter two are a radiologist and a pathologist, respectively, whose homes are in Omaha.

Dr. John S. Koch was installed, December 18, as president of the medical staff of Mercy Hospital, Cedar Rapids. **Dr. Carl R. Aschoff** was named president-elect; **Dr. John P. Jacobs**, vice-president; and **Dr. Richard M. Quetsch**, secretary-treasurer.

The "cover story" subject for the December 15 issue of MODERN MEDICINE was **Dr. Dean M. Lierle**, professor emeritus of otolaryngology and maxillofacial surgery at the University of Iowa. Dr. Lierle, now 74 years of age, took his M.D. at Iowa in 1921. He is executive secretary-treasurer of the American Board of Otolaryngology, and educational director for the Society of University Otolaryngologists. His other offices and accomplishments, past and current, make a very impressive list.

A by-line article in the December 21 issue of the DAVENPORT DEMOCRAT quoted **Dr. Robert E. Durnin**, an assistant professor of pediatrics at the U. of I. College of Medicine on the capabilities of a small computer called the PhonoCardioScan developed at the University. It is an 11-pound rectangular metal box containing electronic gear. It "listens" to heart sounds, and when it "hears" anything not within the normal range of sounds that have been programmed into it, a light flashes.

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When that happens in a screening examination, the subject is referred for further tests. Dr. Durnin was quoted as saying, "Nearly seven school-age children out of every thousand suffer from some form of heart disease, and 45 to 50 per cent of these cases go undetected because the problem is mild enough that it does not cause serious trouble until later years. It was with this in mind that we started the project. We wanted to develop a diagnostic tool that could be used to screen schoolchildren for heart disease on a mass basis." He told the reporter that it is being used in the schools of Illinois and four other states, and that in Iowa it has been used, to a limited extent, by the pediatric clinics at University Hospitals and by the State Services for Crippled Children. The school nurse can use the machine to screen 80 or 90 children per day.

There has been one last—probably inconsequential—development in what the BURLINGTON HAWKEYE-GAZETTE calls "The Great Medical Examiner Flap" in Des Moines County. It started when the county supervisors there were unable to get any physician to accept the post of medical examiner and, at the suggestion of the doctors, appointed all of them deputy medical examiners. Next, the state auditor questioned the legality of paying various physicians for viewing bodies, conducting autopsies, etc. when there was no county medical examiner. Then, **Dr. Orville Dawson** agreed to act, nominally, as medical examiner, so that everything might be legal. Finally, in mid-December an attorney general's opinion, which had been requested by the county attorney, declared that the law had *not* required the post of medical examiner to be filled. There have been no further changes in medical-examiner arrangements.

Dr. Eduardo Reviez, of Cali, Colombia, returned to the United States and joined **Drs. T. R. Viner, Thomas R. McMillan** and **Jerry Edelman** at Leon on January 1. He received his M.D. in his native country in 1962, and served an internship and a residency in general surgery at University Hospitals, Iowa City, completing his work there in 1967. Since then he has served as a Peace Corps surgeon and a medical faculty member in Colombia. **Mrs. Reviez** is a Laurens girl whom he met in Iowa City.

Dr. Arnold M. Reeve has resigned the post of Nebraska Commissioner of Health to accept the comparable position in Iowa. Dr. Reeve took the Lincoln job in October, after having been director of the Division of Preventive Medicine in the

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Iowa State Department of Health, and actually hadn't disposed of his home in Des Moines at the time he agreed to return there. **Dr. James M. Speers** the most recent Iowa Commissioner of Health, took charge of the Omaha-Douglas County Health Department on January 1. According to newspaper accounts, Dr. Reeve was willing to delay coming back to Iowa for another month, while Nebraska authorities found someone with whom to replace him.

A postdoctoral research associate in chemical engineering at the U. of I., **Sennen Uy, Ph.D.**, in cooperation with **Dr. Richard Lawton,** a professor of surgery at the U. of I., has developed a technique for coating silicone rubber with a material that prevents blood-clotting. It is expected to help avoid complications in the use of artificial—as distinguished from transplanted—organs, and also is likely to be used in heart-lung and artificial kidney machines. Thus far, experiments have been conducted with only animals as "patients."

Dr. Adolph L. Sahs, head of neurology at the University of Iowa College of Medicine, has been named general chairman of the new Joint Committee for Stroke Facilities, by the American Neurological Association and the HEW Regional Medical Programs. The Committee will develop guidelines and criteria for the care of stroke patients, including prevention, diagnosis, treatment, rehabilitation and related specialty training.

The speaker at the Charles City Kiwanis Sunrisers' meeting, December 22, was **Dr. Werner Pelz.** He discussed drug abuse.

A computerized x-ray machine has been installed at Allen Memorial Hospital, Waterloo, at a cost in excess of $100,000, according to **Dr. Maurice M. Wicklund,** one of the three radiologists who work with it. According to a December 28 story in the WATERLOO COURIER, directions can be punched out on a card. When the card has been fed into the computer and the patient has been anesthetized, physicians and technologists can step behind a protective lead wall and can watch the procedures through a window. As they watch, the computer moves the table to position the patient with the cameras and fluoroscope, injects the contrast medium, snaps the picture or activates television or movie cameras, repeating the processes until the examination has been completed.

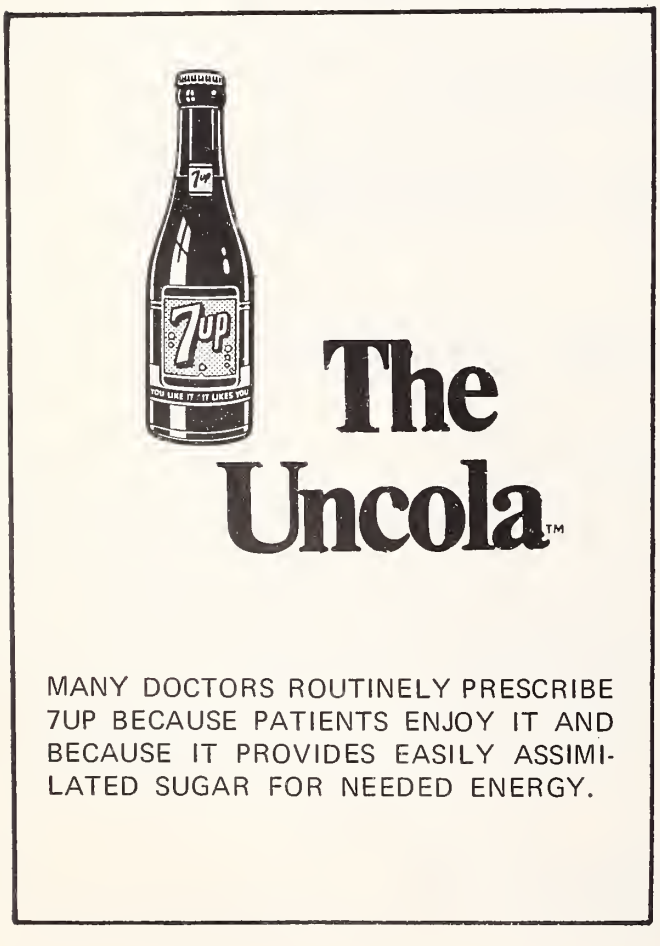
Dr. James D. Mahoney, of Council Bluffs, was named by **Governor Robert D. Ray,** late in December, to take the place of the late **Dr. James O. Cromwell,** of Des Moines, on the Iowa Comprehensive Health Planning Council. As Dr. Cromwell was, Dr. Mahoney is a psychiatrist.

On January 5, **Dr. Kirk H. Strong** was elected president of the Fairfield Chamber of Commerce. He is a former city councilman, he has been active in partisan politics, and he has been active in Boy Scout and other community affairs.

Dr. Jack D. Fickel, of Red Oak, was elected president of the State Board of Public Instruction on January 2. He has been a member of the Board for four years.

Dr. James A. Bullard returned late in December from a five-week Sierra Club expedition to Nepal and Mt. Everest. It was not an attempt to scale Everest, he says. "We didn't carry any oxygen with us, and scaling the 18,000-foot peaks near Everest is about the limit for an untrained person without oxygen. . . . It was impossible to hurry at that altitude. If you laced your boots too fast, you would be out of breath. When we climbed Kala Pattar, the last 150 feet took an hour. Every step was agony."

Dr. Bullard carried medical supplies with him as far as the base camp, 150 miles from Katmandu,



Nepal, and he practiced medicine among the Nepalese en route. "It is the hardest work I have ever done," Dr. Bullard says. He estimated that 90-95 per cent of the Nepalese are afflicted with parasitic diseases. Tuberculosis is the second commonest disease. "We would make camp about 3:30 p.m., and even though we were miles from the nearest village, suddenly there would be people wanting medical treatment. It was almost as if they came out of the rocks." The nearest doctor for most of the people is five or 10 days' walk distant. "I've always thought of myself as a stable person, but I have never been so depressed in my life," he declares. "I treated a boy my son's age. He was about half the size of my son and had wasted extremities and a huge potbelly. He was starving to death and had a gross infection. There was so little I could do in the short time we were there to save him!"

Dr. Lloyd J. Filer, Jr., a professor of pediatrics at the U. of I. College of Medicine, has been appointed chairman of the Committee on Nutrition of the American Academy of Pediatrics. The Committee is concerned with standards for nutrition as they affect infants, children and adolescents.

The coronary care unit at Ottumwa Hospital was explained to Evening Kiwanians on December 29 at the Holiday Inn, Ottumwa, by **Dr. Lloyd Gugle**, coronary care committee chairman at the hospital.

Dr. John R. Parish, of Grinnell, has been elected to a third one-year term as chief of staff at Grinnell General Hospital. **Dr. H. Raymond Light**, also of Grinnell, was elected to a third term as vice-president, and **Dr. Robert M. Carney**, of Brooklyn, was elected secretary.

The Board of Supervisors for Pottawattamie County has appointed **Dr. Arthur M. Pedersen** county medical examiner, replacing **Dr. Jose V. G. Angel**, who has held the post for the past three years.

On the afternoon of January 2, fire damaged the offices of **Dr. Emerson K. Wirtz**, a West Des Moines general practitioner. The fire itself was confined to the furnace room, but there was heavy smoke, heat and water damage to the rest of the building. It was estimated that the loss would amount to nearly $6,000.

Dr. F. H. Coulson, of Burlington, spoke to a meeting of Des Moines County Heart Association volunteers, January 9, on the importance of combatting cardiovascular disease.

At the January 6 meeting of the Wapello County Medical Society, in the Ottumwa Country Club, the guest speaker was **Dr. John H. Kelley**, a Des Moines orthopedist and chairman of the IMS Committee on Legislation. His topic was "Legislation 1970."

At a meeting on December 30, **Dr. A. F. Benetti** was elected chief of staff of the Belmond Community Hospital, replacing **Dr. G. J. Hruska**.

Dr. Charles Field, who practiced for 13 years at Cresco during the late 1940's and 1950's, and since then has served a residency at the Mayo Clinic, has done some medical missionary work in Africa, and has been a staff member of the Olmsted Medical Group, in Rochester, Minnesota, has accepted a position on the faculty of the University of Nebraska College of Medicine, in Omaha. He is an obstetrician and gynecologist.

Dr. George R. Zimmerman, a professor of pathology at the U. of I., succeeded **Dr. Christian E. Schrock**, a private practitioner in Iowa City, as president of the Johnson County Medical Society, at the organization's meeting January 7 in the Iowa City Veterans Hospital. The speaker of the evening was **Dr. John S. Thompson**, a professor of internal medicine who came to the U. of I. from the University of Chicago at the start of the current academic year. His topic was "Applications of the Lessons of Transplantation Immunology to Clinical Medicine."

Dr. Frank J. Ilardi and **Dr. S. A. S. Makki** have joined the psychiatric residency program at the Cherokee Mental Health Institute. Dr. Ilardi was born in New York City, took his pre-medical and undergraduate medical work at the University of Tennessee, and recently completed his internship at the USPHS Hospital in New Orleans. Dr. Makki is a Pakistani who received his basic medical training at the Dow Medical College in Karachi. He has interned, this past year, at Maumee Valley Hospital, in Toledo, Ohio. Dr. and Mrs. Ilardi have three children.

The guest speaker at the early-January meeting of the Burlington Junior Women's Club was **Dr. Bernardo Pineda.** His topic was "Operation Healthy Babies."

Dr. Jean LePoidevin succeeded **Dr. James Shreffler** as president, and **Dr. Richard Long** succeeded **Dr. Gerald Vandervelde** as secretary of

the medical staff of Schoitz Memorial Hospital, Waterloo, on January 6. **Dr. Gardner Phelps** is the new vice-president.

Thieves were reported to have taken a 30 cc. vial of cocaine from the office of **Dr. John Gallagher,** in Oelwein, while it was unoccupied between New Year's Eve and January 2. They could have taken more narcotics but didn't.

The Valley Clinic, at Ft. Madison, reported early in January that four additional ones of the town's physicians have joined its staff, and that the group will maintain offices at Sixteenth and Avenue E, as well as at Twentieth and Avenue E. They are **Dr. Robert E. Murphy** and **Dr. John McGee,** obstetricians and gynecologists; **Dr. Harry Harper, Jr.,** psychiatrist; and **Dr. Marilyn Harper,** anesthesiologist. **Dr. Robert L. Kent,** an obstetrician and gynecologist, is to move to the Sixteenth Street address as soon as some remodeling has been completed. The Drs. Harper are to have their offices there, too. The group now totals 12.

The following Iowa physicians have been reappointed to AMA councils or committees: **Donovan F. Ward, M.D.,** Dubuque, Council on Legislative Activities; **Lauren A. Woods, M.D.,** Iowa City, Council on Drugs; **R. A. Berger, M.D.,** Davenport, Committee on Quackery; **R. G. Carney, M.D.,** Iowa City, Committee on Cutaneous Health and Cosmetics; **Rubin H. Flocks, M.D.,** Iowa City, Interspecialty Committee.

Dr. Donald B. Kettelkamp, an associate professor of orthopedic surgery at the U. of I. College of Medicine, has been investigating frostbite ever since he engaged in private practice at Anchorage, Alaska. After moving to New York, he and two associates performed animal experiments to evaluate the extent of damage to tissues from exposure to low temperatures. Determining the blood flow provided a way of predicting whether gangrene would follow exposure to cold and, in turn, cause a loss of tissue. Animals were given intravenous injections of a protein tagged with radioiodinated human serum albumin (RISA I^{131}). Those which showed a fairly even tapering off of radioactivity in the affected areas recovered fully, but those which showed a slower and more erratic decline of radioactivity suffered subsequent tissue loss. Clinical estimates of tissue damage in frostbite patients average 60 per cent accurate, but estimates based upon this slowdown in loss of radioactivity between 48 and 96 hours following exposure to cold reach 85 per cent accuracy, Dr. Kettelkamp says. His is a means of determining *whether* tissue damage will occur; not a means of predicting how much.

Dr. Harry B. Weinberg has been named coordinator of the Iowa Regional Medical Program, replacing **Dr. Willard A. Krehl.** Dr. Weinberg, formerly a Davenport cardiologist, joined the IRMP staff at Iowa City last July as program director. His M.D. is from the University of Nebraska, and he received his specialty training at Michael Reese

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Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Hospital, Chicago. He is a former president of the Iowa Heart Association, and a member of the board of directors of the American Heart Association.

At the annual meeting of the Dallas-Guthrie County Medical Society, held at the Library Hall, Dexter, in January, **Dr. C. A. Nicoll,** of Panora, was elected president for 1970; **Dr. Robert Deranleau,** of Perry, was elected vice-president; and **Dr. Keith M. Chapler,** of Dexter, was named secretary-treasurer. **Dr. Alfred N. Smith,** a Des Moines general surgeon, spoke on peripheral vascular diseases of the lower extremities.

Deaths

Dr. Emery Ernest Magee, 89, who practiced medicine in Waterloo for 50 years, prior to his retirement in 1957, died at the Lutheran Home in Cedar Falls on December 31. He was a graduate of the Iowa State Teachers College, now the University of Northern Iowa, and of the Northwestern University Medical School. He was a Life Member of the Iowa Medical Society.

Dr. Harry F. Kiesling, 79, who practiced at Lehigh for over 50 years, died at Bethesda General Hospital, Fort Dodge, on December 27 following a short illness. He was a 1916 graduate of the medical school at the University of Iowa, and practiced briefly at Dayton, Iowa, before entering the Armed Forces for World War I. Following service as a medical officer in France, he began work in Lehigh in 1919. He was a Life Member of the Iowa Medical Society.

Dr. Roy Randolph Jeffries, 78, a Waukon physician for 50 years, died on December 12 at a hospital in Rochester, Minnesota. He received his medical degree from St. Louis University in 1919, and started practice in Iowa immediately thereafter. He was president of the Waukon School Board for 12 years.

Dr. Walker B. Henderson, 62, died on December 19 in an ambulance that was returning him from Rochester, Minnesota, to Mercy Hospital, Oelwein. His boyhood home was in Independence, Iowa; he took his M.D. at Iowa City in 1931; he interned in Salt Lake City and then spent a year each on the staff of the Mental Health Institute at Independence and in a pediatrics residency in Chicago; engaged in private practice for a year in Kemmerer, Wyoming; and finally settled in Oelwein. Except for active duty with the Air Force during World War II, he worked in Oelwein until 1968, when he and his wife decided to move permanently to their home north of Brainerd, Minnesota.

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Index to Advertisers

American Medical Association 142
Arch Laboratories 130
Arnar-Stone Laboratories, Inc. 122

Burroughs-Wellcome & Co. 82A

Campbell Soup Company 108A
Casualty Indemnity Exchange 143
Chicago Medical Society 133

Geigy Pharmaceuticals 82B, C

Hoechst Pharmaceuticals 119
Hynson, Westcott & Dunning, Inc. 75

Lederle Laboratories 77, 83, 132
Lilly, Eli, & Company 73, 84

Medical Protective Company 136

National Drug Company 74, 90A, B

Parke, Davis & Company 134C, D
Polk County Medical Society 79
Prouty Company 131
Poythress, Wm. P., & Company 134A

Robins, A. H., & Company 80, 108D, 126A, B, 127, 134B
Roche Laboratories 144

Sandoz Pharmaceuticals 82D
Searle, G. D., & Company 108B, C
Seven-Up Bottlers of Iowa 134
Smith, Kline & French Laboratories 137

JOURNAL of The IOWA MEDICAL SOCIETY



IN THIS ISSUE:

- Program, IMS Annual Meeting
- Tetralogy of Fallot—Robert E. Durnin, M.D., Dorothy A. Ehmke, M.D., and John B. Flege, M.D.
- Neurologic Abnormalities Complicating Severe Renal Disease—Robert L. Rodnitzky, M.D.
- Possible Traumatic Rupture of Aortic Valve, Bacterial Endocarditis and Bilateral Coronary Embolism—Gerald J. Shirk, B.S., and Michael E. Korns, M.D.
- Peripheral Blood Response to Thyrotoxicosis —D. L. Landstrom, M.D., H. E. Hamilton, M.D., and R. F. Sheets, M.D.

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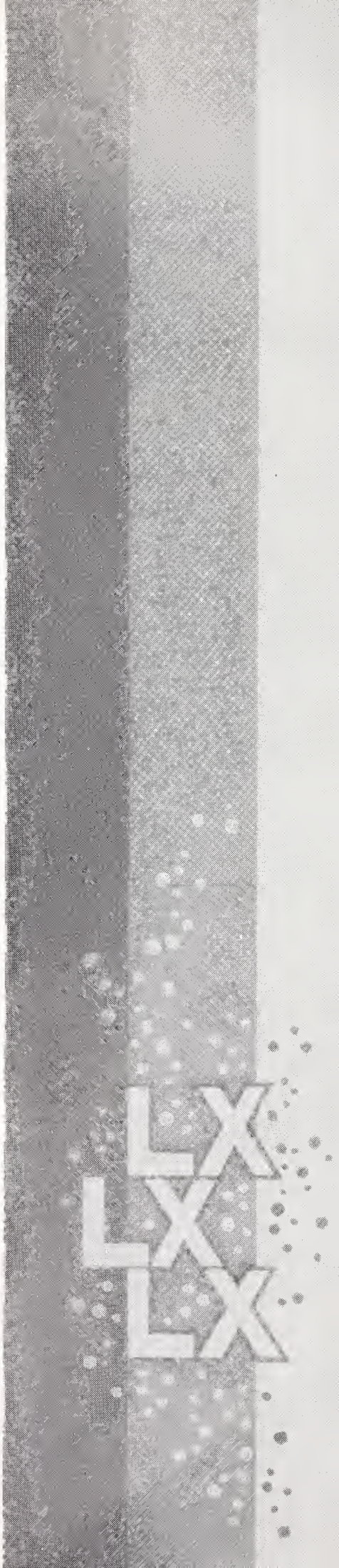
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The JOURNAL of THE IOWA MEDICAL SOCIETY

Vol. LX MARCH, 1970 No. 3

CONTENTS

SCIENTIFIC ARTICLES

Tetralogy of Fallot
Robert E. Durnin, M.D., Dorothy A. Ehmke, M.D., and John B. Flege, M.D. 171

Neurologic Abnormalities Complicating Severe Renal Disease
Robert L. Rodnitzky, M.D. 176

Possible Traumatic Rupture of Aortic Valve, Bacterial Endocarditis and Bilateral Coronary Embolism
Gerald J. Shirk, B.S., and Michael E. Korns, M.D. 180

Peripheral Blood Response to Thyrotoxicosis
D. L. Landstrom, M.D., H. E. Hamilton, M.D., and R. F. Sheets, M.D. 183

EDITORIALS

Long and Distinguished Service 187

What Troubles Troubled Youth 187

Ingestion of Caustic Substances 189

Worldwide Regulations Regarding Preventive Medicine Need Strengthening 191

SPECIAL DEPARTMENTS

Month in Washington 153

Program, IMS Annual Meeting 157

President's Page 186

Information from the Iowa Heart Association: "Use of Anti-Arrhythmic Agents Other Than Digitalis," Leonard S. Dreifus, M.D. . . . 192

Coming Meetings 194

Doctor's Business 196

Iowa Association of Medical Assistants . . . 198

Woman's Auxiliary News 199

State Department of Health 204

Personals 209

Deaths 216

In the Public Interest facing page 222

MISCELLANEOUS

Fourteenth Annual Blank Hospital Pediatric Conference 185

Camp Hertko Hollow 207

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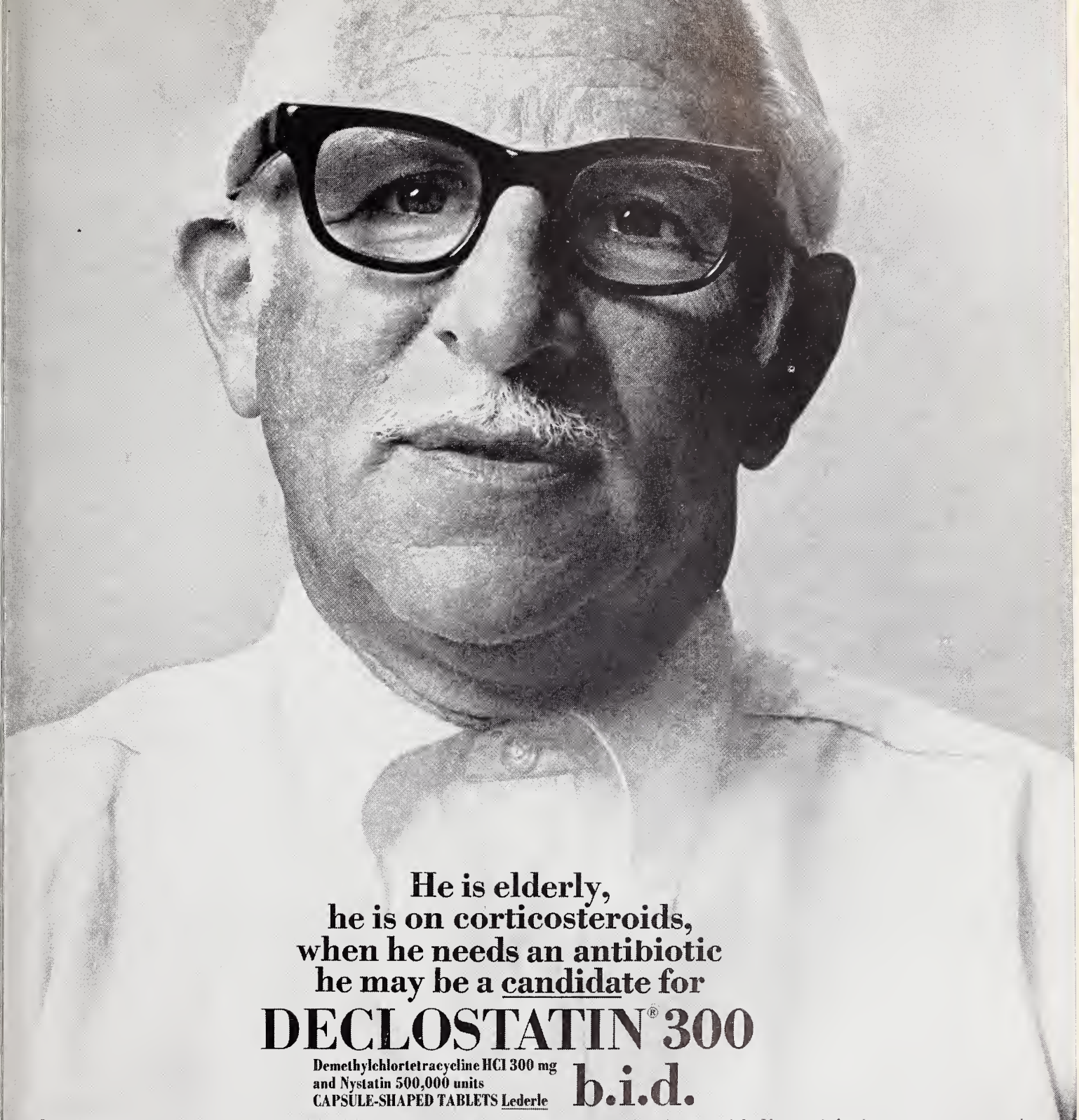
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Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

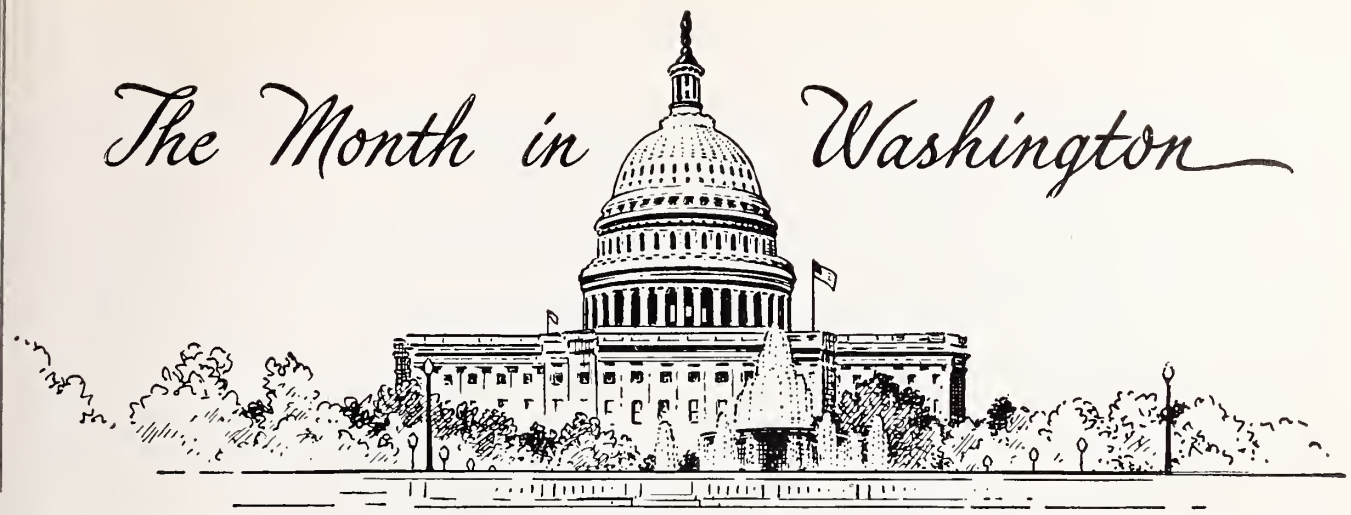
Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
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Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

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The Month in Washington



Washington—The Senate Finance Committee approved a staff report on Medicare and Medicaid which was critical of both physicians and the administrators of the health care programs. It included a recommendation for fee schedules for physicians' services.

In a joint statement, the presidents of the American Medical Association and the National Medical Association pledged the support of their organizations for the Committee's efforts to correct deficiencies and abuses in the two programs. However, the two spokesmen for organized medicine said, "It would be tragic if . . . regulations were adopted whose effect would be to deny a greatly improved level of health care to the ghettos."

The AMA-NMA statement said, "We were greatly encouraged by the Committee's comment that it 'believes the majority of physicians for whom information was requested with respect to Medicare and Medicaid as presently structured have dealt fairly with these federal programs and with the federal government.' "

In regard to abuses and fraud, the statement said:

"Where these abuses exist, they must be rooted out. Both the AMA and the NMA are prepared to take very vigorous action, within their power, to help the Committee and the government accomplish this."

It was noted that the Committee had denied an AMA request many months ago that it be given the names of physicians involved in the Committee's investigation.

"Despite this," the statement said, "the AMA and the NMA, through their own resources, have been able to identify a number of physicians grossing more than $25,000 in these programs. . . .

"In some instances, medical societies had already taken appropriate action against individual physicians, where the evidence warranted. In other instances, however, the AMA and the NMA have found that many of the physicians presumably included in the Committee's study are dedicated physicians working in isolation in slum and rural areas who are literally being overwhelmed by a tide of sick humanity. . . .

"We therefore believe it would be unfortunate if the Committee's report leads the public to believe that Medicare and Medicaid are riddled with fraud or that the number of physicians abusing the programs is large. Such is not the case. . . ."

The report said incomplete and partial listings indicated that 4,300 individual practitioners plus an additional 900 physician groups each received at least $25,000 from Medicare in 1968, including 68 who received $100,000 or more. The report also included a long list of physicians by state receiving $25,000 or more from Medicaid in 1968. None was named; listings were by code numbers.

* * *

"Hundreds of the payment profiles indicate that the physicians involved might be abusing the program," the report said. "For example, we found many general practitioners each paid $15,000, $20,000, or more for laboratory services. We found large payments being made for what appear to be inordinate numbers of injections. In many cases we found what is apparently overvisiting and gang-visiting of patients in hospitals and nursing homes.

"The staff believes that the majority of physicians on whom information was gathered provided medically necessary services for which they were entitled to charge and be reimbursed. On the other hand, Medicare's payment structure did little to discourage—in fact, it encouraged—high fees, and thus may well have contributed to the very substantial payment totals to those same physicians."

Recently, the Social Security Administration reported that about 2,500 cases had been investigated for fraud or abuse during the first three and one-half years of Medicare. It was emphasized that this was only a minuscule fraction of total Medicare transactions. Social Security Commissioner Robert M. Ball said: "Medicare pays about 30 million doctors' bills and 12 million bills from institutional providers of services each year. It is clear from our investigations that the number of attempts at fraud or abuse is relatively very small."

About half of the cases investigated, he said, resulted from clerical errors, misunderstandings or honest mistakes by physicians and health services.

To Jan. 20, 1970, the SSA had referred the cases of 13 individuals and organizations to the Justice Department with recommendations for criminal prosecution for fraud. Two physicians have been convicted in U. S. district courts, and indictments have been returned against another five physicians and one non-physician. Another five cases had been referred with recommendations that civil proceedings be started for the return of illegally collected funds. Early this year, Social Security investigators also were preparing an additional 35 possible fraud cases for referral to the Justice Department.

The most common types of alleged violations included physicians and other providers' billing for services not rendered, excessive charges, alteration of bills, duplicate billings, misrepresentations of types of services or dates of services, unreported discounts or kickbacks, and employee embezzlements, Medicare officials said.

The report's recommendations were aimed at providing "bases for remedying the serious, costly, and pervasive problems" of the two programs, and for making them "work more efficiently and economically." However, it was conceded that physicians constituted the cardinal factor.

"The key to making the present system workable and acceptable is the physician and his medical society," the Committee staff said. "We are persuaded that at this point in time neither the government nor its agents have the capacity to effectively audit medical practice to assure that a given physician functions responsibly in dealing with the publicly financed programs.

"While there is growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance has been spotty and isolated so far. Prompt action is necessary by organized medicine (and other health professions) to do what is required with respect to monitoring care provided and charges made for the care. . . .

"However, procedures which involve peer review should not be undertaken without precise spellings out and assurances that such review will be comprehensive and effective—not paper and token."

Report recommendations:

—Fee schedules for physicians' services.

—Generic prescribing of drugs.

—"Curbing of overutilization by requiring prior professional approval of elective procedures and expensive courses of treatment."

—Requiring the patient to name a "primary physician" and to end "costly 'doctor shopping.'"

—Requiring states to provide Medicaid recipients with statements outlining payments made in their behalf.

—Modifying present law "to make practicable reasonable cost-sharing payments by the medically indigent."

—Prohibiting independent collection and discount agencies from collecting Medicaid or Medicare due bills that providers have sold to them.

—Improving federal administration, and establishing cooperative arrangements with and between states.

—Establishing a Medicaid fraud and abuse unit in HEW, and requiring states to establish similar units.

—Combining the Medicare and Medicaid advisory councils.

* * *

The American Medical Association urged changes in proposed federal regulations concerning fraud under the Medicaid program. "While we do not condone in any way any fraudulent conduct of physicians in Title XIX (Medicaid) or in any professional activity, we do believe that physicians will consider the new requirements an unwarranted affront to their integrity in their participation in the program," Dr. Ernest B. Howard, executive vice-president of the AMA, said in a letter to John D. Twiname, acting administrator of the Medicaid program.

One of the proposed regulations would require physicians to sign form statements certifying that their claims were correct and that they understood fraud could subject them to prosecution. These statements, Dr. Howard said, would serve no useful purpose because physicians already know that false claims can lead to prosecution. On the other hand, the regulation would be "regarded as offensive by many physicians, since it obviously impugns their integrity," the AMA letter said.

The other proposed regulation would require state agencies to report suspected cases of fraud promptly.

"It is obvious that serious prejudice may result to a physician where the suspicion of fraud is publicized," the AMA said. "Even when the fraud is not later established, irreparable harm to the reputation of the physician will still have resulted. . . . We believe it will be better procedure not to report each suspected case, but to include in the report only those situations where the case has been concluded and fraud has been established."

* * *

The Nixon Administration submitted a fiscal 1971 budget calling for federal expenditures of $20.6 billion from general revenues for health purposes, an increase of $1.8 billion over current spending levels. Medicaid and Medicare Part B (physicians' services) accounted for much of the increase.

The overall Medicare budget, including Part A (hospitalization), increased by $1.2 billion to $8.8 billion. Estimated Medicaid costs to the federal government rose from $2.6 billion to $3.1 billion. However, the Administration hopes to cut the Medicaid budget $235 million by getting Congress to approve the elimination of federal aid for extended care in mental institutions and nursing homes.

The budget for the current 1970 fiscal year, ending next June 30, still had not been approved when the new budget was submitted. Congress upheld President Nixon's veto of the appropriations for the Departments of Labor and of Health, Education and Welfare on the ground that it was inflationary. The main funds at issue consisted of educational aid for the federally impacted areas. The Administration and Congressional leaders negotiated a compromise regarding them.

In the 1971 budget, the lid was kept on health research spending by holding the overall increase in funds requested for the National Institutes of Health to $48 million. Some of the institutes' programs were cut, and others were given only small increases. Cancer research was allotted the largest increase, $28 million, pushing the 1971 budget for the program to $202.3 million. Heart research and child-health research were increased by $17 million each.

Increases totaling $15.4 million were asked for alcoholism and drug addiction programs.

The Food and Drug Administration budget was upped by 10 per cent, from $81.3 million to $89.5 million. Of this hike, nearly $2 million would be used to check safety of food additives, and $2.2 million would be used for research on cancer and birth defects in animals exposed to pesticides.

A boost of $12.4 million, to $57.4 million, was requested for health services research and development projects "directed primarily at containing the rate of increase of medical care costs and improving the availability and utilization of health care, especially for low income groups." The federal programs in this field include: the development of alternatives to long-term stays in hospitals; experiments with private insurance firms to develop additional policies to encourage out-of-hospital care; experiments with comprehensive prepayment plans; improvement of municipal hospital systems; and development of new types of health service manpower.

An increase of $25 million, to $320 million, was requested for health professions education and manpower training programs.

* * *

The pros and cons, with emphasis on the cons, of birth control pills were aired at a Senate subcommittee hearing. Most of the physician witnesses at four days of hearings by the Senate Antimonopoly Subcommittee testified that not enough attention had been paid to side-effects. They urged both physicians and drug companies to be more diligent in calling patients' attention to the possible dangers in taking oral contraceptives.

Some of the witnesses expressed strong concern or alarm as to the side-effects. Others defended the oral contraceptives.

Developments related to the hearings included:

—The Food and Drug Administration revived its birth control advisory committee which last fall concluded that the benefits of oral contraceptives outweighed the possible dangers so heavily that they could be evaluated as "safe." Dr. Roy Hertz, New York, N. Y., a critical witness before the Subcommittee, was named its temporary chairman.

—In advising physicians about the new labeling, the new FDA commissioner, Dr. Charles C. Edwards, urged that patients be given full information about potential adverse effects.

—The American College of Obstetricians and Gynecologists said it "deplored inaccurate or sensational reports concerning the scientific data on these drugs." The pills were termed "accepted therapeutic methods."

—In a televised interview, Dr. E. B. Howard, executive vice-president of AMA, urged American women to be calm in the face of the wide publicity about side effects, and to follow the orders of their physicians.

—The AMA's Council on Drugs said: "Oral contraceptives should continue to be prescribed by physicians for patients who require this type of contraception. However, we urge that patients be advised that there are certain risks involved—the slight risk of vascular damage and the theoretical risk of carcinoma."

Diagnosis and Care of the Battered Child

Friday, May 8, 1970

Sponsored by the Department of Pediatrics, University of Iowa and the School of Law, University of Iowa

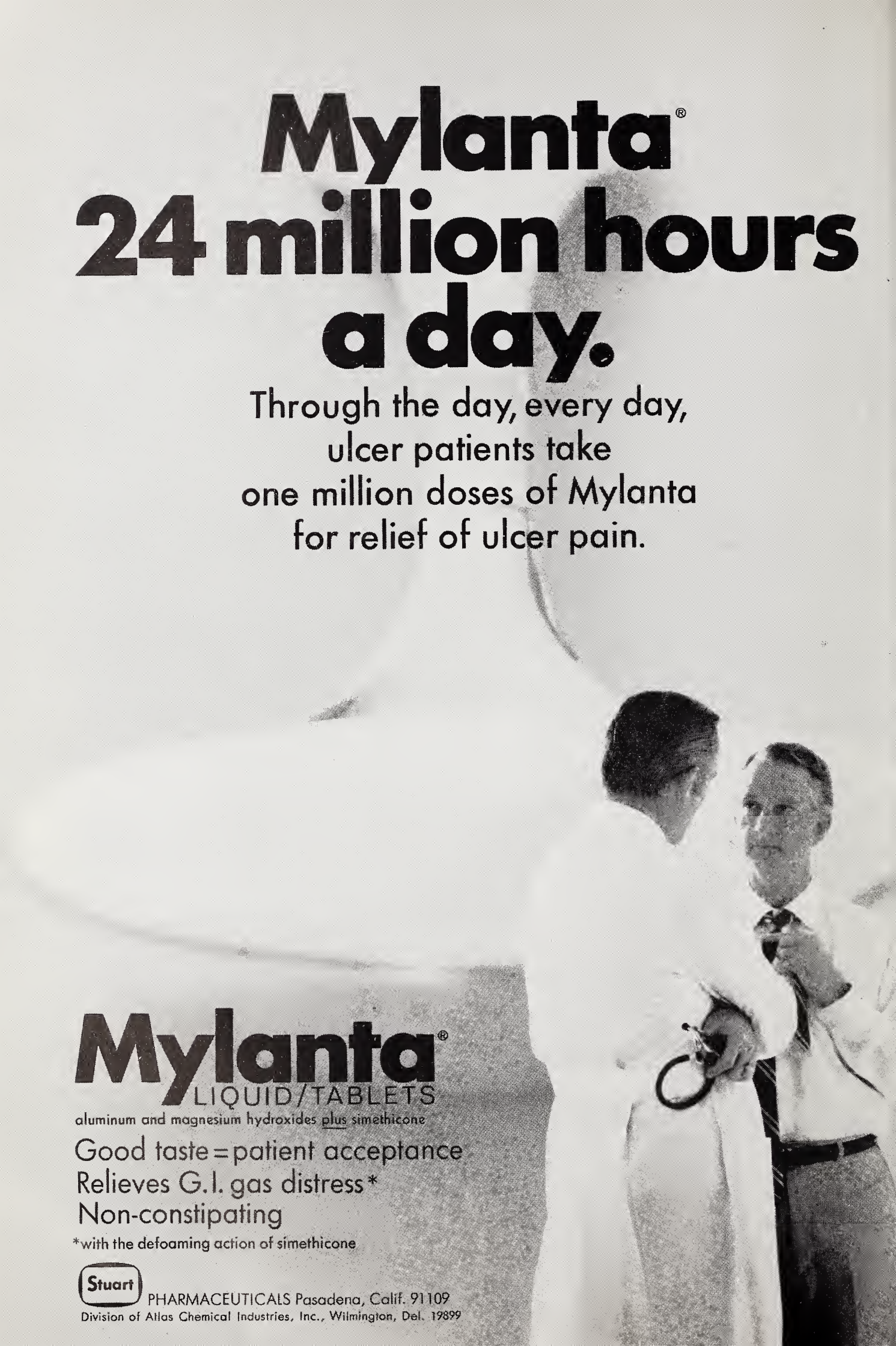
Iowa Memorial Union

8:00 a.m. Registration (Fee—$15.00)
9:00 a.m. Welcome—Donal Dunphy, M.D., head, U. of I. Department of Pediatrics
9:10 a.m. "Helping the Abused Child and the Family"—Ray Helfer, M.D., chairman, Department of Pediatrics, Catholic Medical Center of Brooklyn and Queens, New York City
9:40 a.m. "Psychodynamics of Child Abuse"—Carl Pollock, M.D., assistant professor of psychiatry, University of Colorado School of Medicine, Denver
10:10 a.m. Orientation for Small Group Discussions
10:30 a.m. SMALL GROUP DISCUSSIONS
1. Dr. Helfer
2. Dr. Pollock
3. Mr. Joseph Montgomery, director of social services, U. of I. Hospitals
4. Professor Samuel Fahr, U. of I. College of Law

12:00 noon LUNCH
1:15 p.m. "X-ray Diagnosis of the Abused Child"—Albert Selke, M.D., assistant professor of radiology, U. of I. College of Medicine
1:30 p.m. "Legal Aspects"—Professor Fahr
2:00-3:00 p.m. SMALL GROUP DISCUSSIONS
3:30-4:00 p.m. ROUND TABLE—Dr. Helfer, Dr. Pollock, Mr. Montgomery, Professor Fahr and Dr. Andre Lascari, assistant professor of pediatrics, U. of I. College of Medicine

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24 million hours a day.

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ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



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LIQUID/TABLETS
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IOWA MEDICAL SOCIETY

Organized in 1850

1970 ANNUAL MEETING

April 26-29

Sunday, Monday and Tuesday Sessions to be held at Hotel Fort Des Moines, Wednesday Session at Hotel Savery, Des Moines



Hotel Fort Des Moines



WM. M. KRIGSTEN, M.D.

President
Iowa Medical Society
1969-1970

GENERAL SESSIONS

Grand Ballroom—Hotel Fort Des Moines

Monday Morning, April 27

8:00 a.m. EXHIBITS—EARLY-BIRD BREAKFAST

8:55 a.m. INVOCATION

CLINICAL PROBLEMS CONFRONTING THE PHYSICIAN

9:00 a.m. "Modern Coronary Care"
Donald L. Warkentin, M.D., Iowa City, Iowa, Associate Professor, Department of Internal Medicine, University of Iowa College of Medicine

9:45 a.m. RECESS TO VISIT EXHIBITS

10:30 a.m. THE BALDRIDGE-BEYE MEMORIAL LECTURE
Presented by the Scanlon Medical Foundation/Iowa Medical Society
"Advances in Emergency Care and Emergency Room Techniques"
Robert J. Freeark, M.D., Chicago, Illinois, Professor, Department of Surgery, Northwestern University Medical School

11:15 a.m. "Intensive Care Units"
Jack Moyers, M.D., Iowa City, Iowa, Professor and Head, Department of Anesthesia, University of Iowa College of Medicine

11:45 a.m. RECESS TO VISIT EXHIBITS

12:00 noon LUNCHEON PROGRAM
"Internal Security"
Otto F. Otepka, Washington, D. C., Member, Subversive Activities Control Board

This Program Is Acceptable for
ELECTIVE HOURS
by the
American Academy of General Practice

MONDAY AFTERNOON SPECIAL SEMINAR SESSIONS

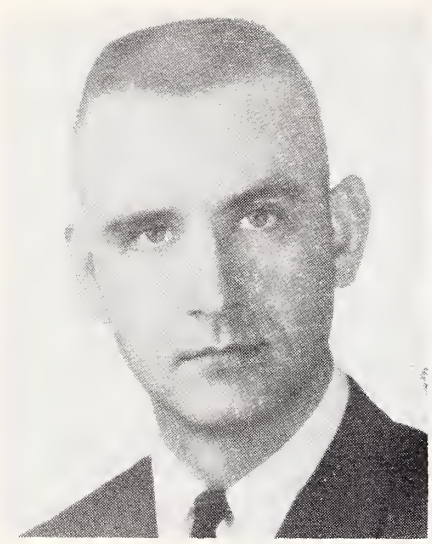
See page 161 for complete details!

AN INVITATION TO IOWA PHYSICIANS

University of Iowa Alumni Association
in cooperation with
University of Iowa College of Medicine
cordially invites
All Iowa Physicians and Their Wives
to attend

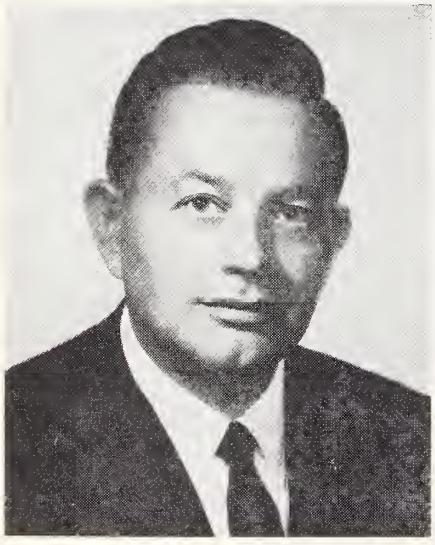
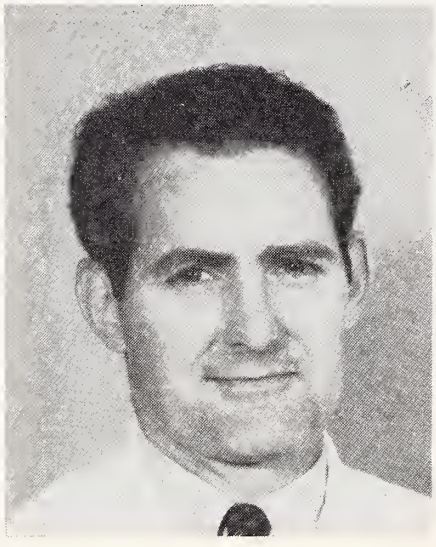
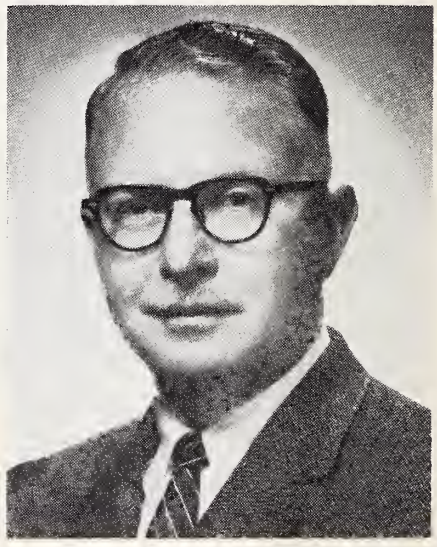
MEDICAL ALUMNI ASSOCIATION RECEPTION

9 p.m. to midnight
Monday, April 27
North Room—Hotel Fort Des Moines





William R. Anderson, M.D., Iowa City, Associate Professor, Department of Obstetrics and Gynecology, University of Iowa College of Medicine. **Leslie Bernstein, M.D., Iowa City,** Professor, Department of Otolaryngology and Maxillofacial Surgery, University of Iowa College of Medicine. **Willard L. Boyd, Iowa City,** President, University of Iowa.

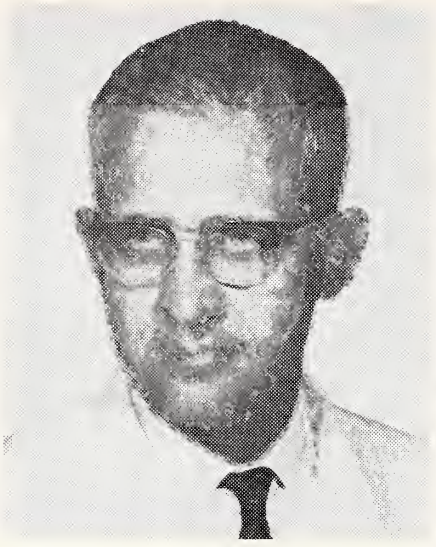
Bertram W. Carnow, M.D., Chicago, Illinois, Professor and Head, Section of Environmental Health, Department of Preventive Medicine, University of Illinois College of Medicine; Medical Director, Tuberculosis Institute of Chicago and Cook County Member, Air Pollution Technical Advisory Committees, City of Chicago and State of Illinois. **Robert E. Durnin, M.D., Iowa City,** Assistant Professor, Department of Pediatrics, University of Iowa College of Medicine; Fellow, American Academy of Pediatrics and American College of Cardiology. **Theodore A. Fox, M.D., Chicago, Illinois,** Associate Professor of Orthopaedic Surgery, Research and Educational Hospitals, University of Illinois College of Medicine; Diplomate, American Board of Orthopedic Surgery; Orthopedic Surgeon, Chicago Bears Football Club; Chairman, Subcommittee on Athletic Injuries of the Chicago Committee on Trauma, American College of Surgeons.

Monday Afternoon, April 27

(Meeting Rooms to Be Designated)

SEMINARS

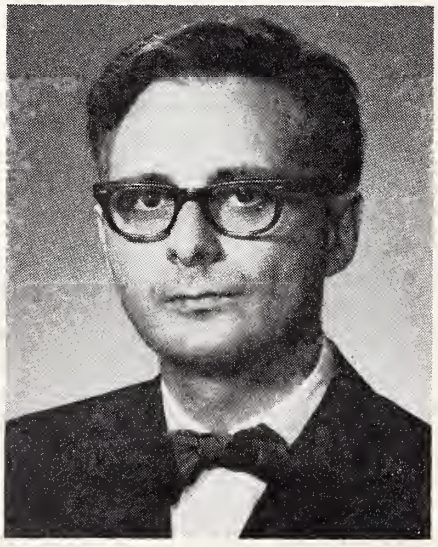
2:00 p.m.	"Recognition of Common Arrhythmias Associated With Myocardial Infarction" Ernest O. Theilen, M.D., Iowa City, Iowa	"Immediate Care of the Severe Chest or Abdominal Injury" Robert J. Freeark, M.D., Chicago, Illinois	"Endometriosis" William C. Keettel, M.D., Iowa City, Iowa	"Recognition of Knee Injuries" Theodore A. Fox, M.D., Chicago, Illinois
2:30 p.m.	"Management of Arrhythmias in Acute Myocardial Infarction" Donald L. Warkentin, M.D., Iowa City, Iowa	"The Care and Maintenance of Airways" Jack Moyers, M.D., Iowa City, Iowa	"Management of Breech Delivery" Clifford P. Goplerud, M.D., Iowa City, Iowa	"Treatment of Knee Injuries" Theodore A. Fox, M.D., Chicago, Illinois
3:00 p.m.	RECESS			
3:45 p.m.	"Cardiovascular Collapse and Cardiogenic Shock" Phillip G. Schmid, Jr., M.D., and Allyn L. Mark, M.D., Iowa City, Iowa	"Acute Head Injuries: Diagnosis and Care in the Emergency Room" Robert Hayne, M.D., Des Moines, Iowa	"Oral Contraceptives" Michael E. Yannone, M.D., Iowa City, Iowa	"Pediatric Heart Sounds" Ronald M. Lauer, M.D., and Robert E. Durnin, M.D., Iowa City, Iowa
4:15 p.m.	"Psychiatric Emergencies" Robert M. Powell, M.D., Mason City, Iowa	"Treatment of Lacerations" Leslie Bernstein, M.D., Iowa City, Iowa	"Management of Patients With an Abnormal Smear" William R. Anderson, M.D., Iowa City, Iowa	"Pediatric Heart Sounds" Ronald M. Lauer, M.D., and Robert E. Durnin, M.D., Iowa City, Iowa

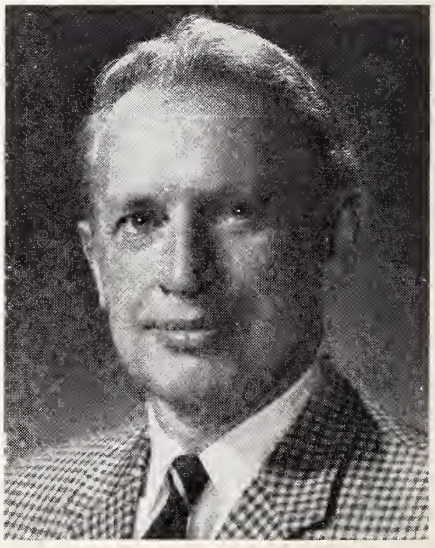




Clifford P. Goplerud, M.D., Iowa City, Professor, Department of Obstetrics and Gynecology, University of Iowa College of Medicine. **Robert A. Hayne, M.D., Des Moines,** Diplomate, American Board of Neurological Surgery; Private Practice.







William C. Keettel, M.D., Iowa City, Professor and Head, Department of Obstetrics and Gynecology, University of Iowa College of Medicine; Diplomate and Vice-president of American Board of Obstetrics and Gynecology; Vice-President, American Gynecological Society. **Ronald M. Lauer, M.D., Iowa City,** Professor, Department of Pediatrics and Director, Section of Pediatric Cardiology, University of Iowa College of Medicine; Fellow, American Academy of Pediatrics. **F. Warren Lovell, M.D., Seattle, Washington,** Consultant Pathologist, Federal Aviation Agency; Clinical Assistant Professor of Pathology, University of Washington School of Medicine; Director of Laboratories, Northwest Hospital; Diplomate, American Board of Pathology.

General Sessions (Continued)

Grand Ballroom—Hotel Fort Des Moines

Tuesday Morning, April 28

8:00 a.m. EXHIBITS—EARLY-BIRD BREAKFAST

MAN'S ENVIRONMENT: SURVIVAL IN THE SEVENTIES

9:00 a.m. President's Address
William M. Krigsten, M.D., Sioux City, Iowa, President, Iowa Medical Society

9:30 a.m. ARTHUR ERSKINE MEMORIAL LECTURE
"Medical Aspects of Aviation Accidents: From the Wright Brothers to the Sputnik"
F. Warren Lovell, M.D., Seattle, Washington, Consultant Pathologist, Federal Aviation Agency

10:15 a.m. RECESS TO VISIT EXHIBITS

11:00 a.m. "Battle of the Century—Man vs. Clean Waters"
Robert L. Morris, Ph.D., Iowa City, Iowa, Associate Director, State Hygienic Laboratory

11:45 a.m. RECESS TO VISIT EXHIBITS

12:00 noon LUNCHEON PROGRAM
"Our Mutual Problems"
Willard L. Boyd, President, University of Iowa, Iowa City, Iowa

Tuesday Afternoon, April 28

2:00 p.m. "Air Pollution: The Nature of the Problem and Physician Responsibility"
Bertram W. Carnow, M.D., Chicago, Illinois, Professor and Head, Section of Environmental Health, Department of Preventive Medicine, University of Illinois College of Medicine

2:45 p.m. RECESS TO VISIT EXHIBITS

3:30 p.m. "Man on the Moon!"
(The National Aeronautics and Space Administration has advised that every effort is being made to arrange for an astronaut to participate in the Annual Meeting program.)

VISIT YOUR EXHIBITS

Hotel Fort Des Moines

Technical Exhibits—
Mezzanine Floor

HOURS

Monday, April 27—
8:00 a.m. to 5:00 p.m.
Tuesday, April 28—
8:00 a.m. to 5:00 p.m.

EARLY-BIRD BREAKFASTS
(Coffee and Rolls)

8:00 a.m. to 9:00 a.m.

Monday, April 27

Tuesday, April 28

North Room—
Hotel Fort Des Moines

Courtesy of Blue Shield





Allyn L. Mark, M.D., Iowa City, Assistant Professor, Department of Internal Medicine, University of Iowa College of Medicine. **Robert L. Morris, Ph.D., Iowa City,** Associate Director, State Hygienic Laboratory; Associate Professor, Department of Preventive Medicine and Environmental Health; University of Iowa College of Medicine; member, Iowa Water Pollution Control Commission. **Jack Moyers, M.D., Iowa City,** Professor and Head, Department of Anesthesia, University of Iowa College of Medicine; Fellow, American College of Anesthesiologists; Diplomate, American Board of Anesthesiology; Member, U. S. Delegation to World Federation of Societies of Anesthesiologists.





Otto F. Otepka, Washington, D. C., Member, Subversive Activities Control Board, by Appointment of President Richard M. Nixon; Former Deputy Director, Office of Security, and Chief Security Evaluator, Department of State. **Robert M. Powell, M.D., Mason City,** Director, Mental Health Center of North Iowa; Member, American Psychiatric Association; Diplomate, American Board of Psychiatry and Neurology. **Phillip G. Schmid, Jr., M.D., Iowa City,** Assistant Professor, Department of Internal Medicine, University of Iowa College of Medicine; Diplomate, National Board of Medical Examiners.

Special Meetings and Dinners

Saturday, April 25

PAST PRESIDENTS' DINNER

Des Moines Club

Social Hour: 6:30 p.m.—Dinner: 7:30 p.m.

Sunday, April 26

GOLF TOURNAMENT

The annual golf tournament will be held at the Willow Creek Golf Course, 63rd and Army Post Road. Reservations for play and golf carts should be made in advance with the course manager. Dinner and awarding of prizes will be held in the evening, at a site to be announced at a later date. *If there is not sufficient interest, the tournament will be cancelled. Make reservations now with: Harold J. McCoy, M.D., 212 Bankers Trust, Des Moines, Iowa.*

Monday, April 27

AMERICAN MEDICAL WOMEN'S ASSOCIATION, IOWA BRANCH 19

Members of the American Medical Women's Association, Iowa Branch 19, should register at the IMS Registration Desk, Hotel Fort Des Moines. If a special meeting is arranged, details will be available at the desk.

IOWA ACADEMY OF SURGERY

Des Moines Club
Business Session—500 p.m.
Social Hour: 6:45 p.m.—Dinner: 8:00 p.m.
Reservations: Mrs. Sue Hyler
Corresponding Secretary, IAS
710 Equitable Building
Des Moines, Iowa

IOWA ASSOCIATION OF PATHOLOGISTS

Des Moines Club
Social Hour: 6:00 p.m.—Dinner: 6:30 p.m.
Reservations: John Green, M.D.
1423 Woodland, Des Moines

IOWA ORTHOPEDIC SOCIETY

Des Moines Club
Social Hour: 6:00 p.m.—Dinner: 7:00 p.m.
Reservations: K. M. Keane, M.D.
508 Frances Building, Sioux City
Guest Speaker: Theodore Fox, M.D.
Chicago, Illinois

IOWA RADIOLOGICAL SOCIETY

Burgundy Room—Des Moines Club
Social Hour: 6:30 p.m.—Dinner: 7:30 p.m.
Reservations: J. H. Lohnes, M.D.
1948 First Avenue S.E.
Cedar Rapids, Iowa

UNIVERSITY OF IOWA ALUMNI ASSOCIATION

in cooperation with

UNIVERSITY OF IOWA COLLEGE OF MEDICINE

Medical Alumni Association Reception
All Iowa Physicians and Their Wives Invited
9 p.m. to midnight
North Room—Hotel Fort Des Moines

Tuesday, April 28

PRESIDENT'S RECEPTION

North Room—Hotel Fort Des Moines
6:00 p.m.

ANNUAL BANQUET

Grand Ballroom—Hotel Fort Des Moines
7:00 p.m.

ARTHUR ERSKINE MEMORIAL LECTURE

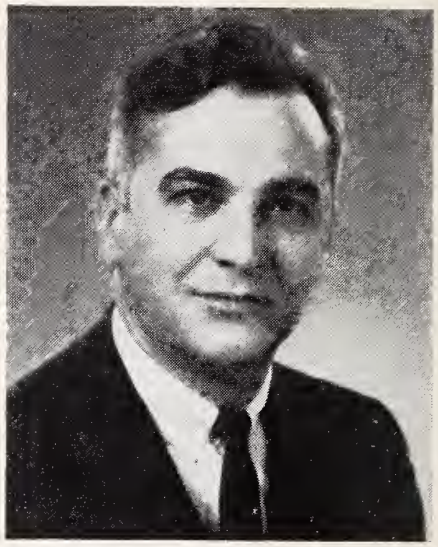
"Medical Aspects of Aviation Accidents"

F. Warren Lovell, M.D.
Seattle, Washington

9:30 a.m.—Tuesday, April 28







Ernest O. Theilen, M.D., Iowa City, Professor of Internal Medicine, University of Iowa College of Medicine; Diplomate, American Board of Internal Medicine and Subspecialty Board of Cardiovascular Diseases; Fellow, American College of Physicians and American College of Chest Physicians. **Donald L. Warkentin, M.D., Iowa City,** Associate Professor, Department of Internal Medicine, University of Iowa College of Medicine; Principal Investigator, Iowa Area, Public Health Service Cooperative Coronary Heart Disease Drug Project; Associate Director, Coronary Care Unit, University Hospitals; Coordinator, Regional Medical Program Training for Physicians and Nurses in Coronary Care Management; Diplomate, American Board of Internal Medicine and Subspecialty Board, Cardiovascular Disease. **Michael E. Yannone, M.D., Iowa City,** Professor, Department of Obstetrics and Gynecology, University of Iowa College of Medicine.

?

The National Aeronautics and Space Administration has advised that every effort is being made to arrange for an astronaut to participate in the Annual Meeting program.

PRESIDENT'S RECEPTION

6:00 p.m.

Tuesday, April 28

North Room–Hotel Fort Des Moines

Blue Shield Is Arranging the Reception in Honor of
Wm. M. Krigsten, M.D., President of the Iowa Medical Society

ANNUAL BANQUET

7:00 p.m.

Tuesday, April 28

Grand Ballroom–Hotel Fort Des Moines

SPECIAL ENTERTAINMENT

Tickets Will Be Sold at the Registration Desk

Hotel Fort Des Moines

The House of Delegates

Open to All Members

First Meeting—Sunday
April 26, 9:00 a.m.

Grand Ballroom
Fort Des Moines Hotel

Roll Call

Approval of the Minutes of the Meeting held on April 30, 1969

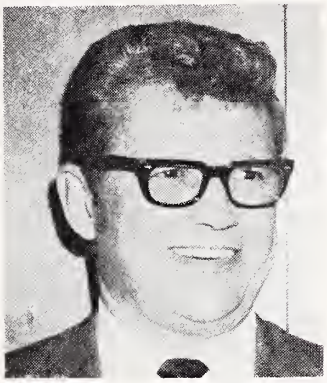
Reports of Officers

Nominations

Reports of Committee Chairmen

Memorials and Communications

New Business



L. D. Caraway, M.D.
Speaker

Second Meeting—Wednesday
April 29, 8:00 a.m.

Grand Ballroom
Savery Hotel

Roll Call

Reading of Minutes

Election of Officers

Reports of Committees

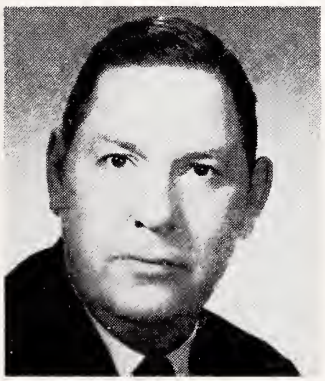
Unfinished Business

New Business

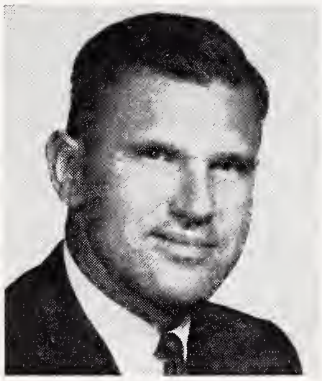
Adjournment

J. H. Sunderbruch, M.D., president-elect, will be installed as President of the Iowa Medical Society on Wednesday, April 29, immediately following adjournment of the House of Delegates.

Program Committee



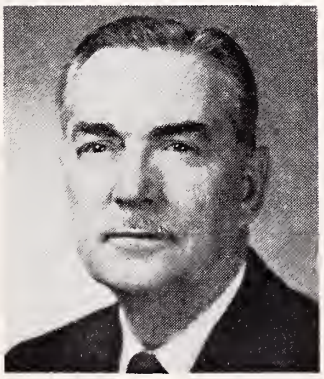
J. E. Tyrrell, M.D.
Chairman



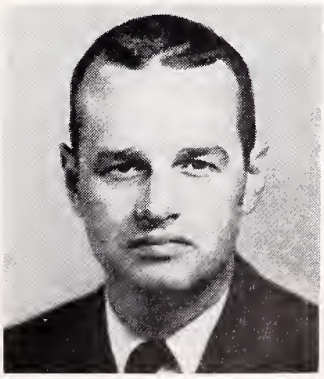
W. R. Bliss, M.D.



H. J. Fishman, M.D.



P. E. Gibson, M.D.



J. H. Kelley, M.D.



W. S. Thoman, M.D.

TECHNICAL EXHIBITORS

Acousticon Woodard Company, Des Moines, Iowa

American Medical Building Guild, Inc., Madison, Wisconsin

Ayerst Laboratories, New York, New York

Blue Shield, Des Moines, Iowa

Casualty Indemnity Exchange, Denver, Colorado

CIBA Pharmaceutical Company, Summit, New Jersey

Dictaphone Corporation, Des Moines, Iowa

Doctors Supply Inc., Iowa City, Iowa

Thomas A. Edison Industries, Des Moines, Iowa

Encyclopaedia Britannica, Chicago, Illinois

General Electric Medical Systems, Des Moines, Iowa

Humetrics Corporation, Los Angeles, California

Imperial Fashions, Los Angeles, California

Iowa Medical Supply Company, Fort Dodge, Iowa

Eli Lilly and Company, Indianapolis, Indiana

J. B. Lippincott Company, Philadelphia, Pennsylvania

Marman Distributors, Des Moines, Iowa

Mead Johnson Laboratories, Evansville, Indiana

Medical Electronics, Waterloo, Iowa

The Medical Protective Company, Fort Wayne, Indiana

Merck Sharp & Dohme, West Point, Pennsylvania

Merrill Lynch, Pierce, Fenner & Smith, Inc., Des Moines, Iowa

Monarch Life Insurance Company, Des Moines, Iowa

Pepsi-Cola Bottlers of Iowa, Des Moines, Iowa

Physicians & Hospitals Supply Company, Minneapolis, Minnesota

Pitney-Bowes, Inc., Des Moines, Iowa

Postal Investment Company, Alleman, Iowa

The Prouty Company, Des Moines, Iowa

J. B. Roerig Division, Chas. Pfizer & Co., Inc., New York, New York

William H. Rorer, Inc., Fort Washington, Pennsylvania

Sandoz Pharmaceuticals, Hanover, New Jersey

G. D. Searle & Company, Chicago, Illinois

Standard Medical, Des Moines, Iowa

Stuart Division/Atlas Chemical Industries, Inc., Pasadena, California

SWEDEX of Des Moines, Des Moines, Iowa

Ulmer Pharmacal Company, Minneapolis, Minnesota

The Upjohn Company, Kalamazoo, Michigan

Warner-Chilcott Laboratories, Morris Plains, New Jersey

Warren-Teed Pharmaceuticals Inc., Columbus, Ohio

Zimmer Dunwiddie Associates, Des Moines, Iowa

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND

OBESITY WAS A MILITARY OFFENSE!
OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!

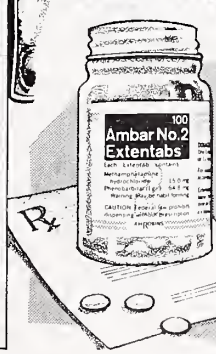


RECORDED ON AN ENGLISHMAN'S TOMBSTONE

JAMES PARSON
DIED 1743
HE HAD OFTEN EATEN A WHOLE SHOULDER OF MUTTON AND A PECK OF HASTY PUDDING

SHAKESPEARE
WAS AWARE OF THE DANGERS OF OBESITY
HE WROTE...

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Scientific Articles

Tetralogy of Fallot

ROBERT E. DURNIN, M.D.,
DOROTHY A. EHMKE, M.D., and
JOHN B. FLEGE, M.D.
Iowa City

Tetralogy of Fallot is the most common congenital cyanotic heart lesion.[1] Before the era of cardiac surgery, the mortality from this condition was high in infancy and childhood.[2] In 1945 Blalock and Taussig performed the first successful palliative surgery for tetralogy of Fallot,[3] and subsequently their "blue baby" operation has improved the health of many infants and children. With the development of the heart-lung machine and improved surgical techniques, during the past several years, open-heart surgery was made possible, and in many instances these children's hearts can now be rendered structurally normal. For this reason tetralogy of Fallot continues to attract increasing attention from the cardiologist and the thoracic surgeon. The purpose of this paper is to discuss the clinical profile, the problems of management and the surgical approaches to tetralogy of Fallot.

In 1888, Fallot[4] described a cyanotic cardiac anomaly characterized by pulmonic stenosis or atresia, ventricular septal defect, dextroposition of the aorta, and right-ventricular hypertrophy (Figure 1). The ventricular septal defect and the degree of pulmonic stenosis are the most important factors from the physiologic standpoint. The pulmonic stenosis may be in the outflow area of the right ventricle (infundibular stenosis), at the pulmonary valve (pulmonary valvular stenosis), or both. The nature and the degree of the stenosis are variable.

The ventricular septal defect is usually large. The severity of right ventricular outflow obstruction (pulmonic stenosis) determines the degree of intracardiac right-to-left shunting from the right ventricle into the aorta, and hence the degree of cyanosis.

CLINICAL PICTURE

The diagnosis can often be suspected on the basis of the clinical findings. The child with tetralogy exhibits cyanosis and, except in infancy, digital clubbing. In toddlers, squatting after exertion is relatively common. There is a systolic ejection murmur originating from the pulmonic stenosis and heard best at the left lower sternal border. The intensity of the murmur varies inversely with the severity of the pulmonic stenosis, there being no murmur with pulmonary valvular atresia. No murmur results from the flow across the ventricular septal defect. Occasionally a continuous murmur is heard from an associated persistent ductus arteriosus or from enlarged bronchial arteries. The second heart sound (aortic- and pulmonary-valve closure) is usually single, with the pulmonary component inaudible or diminished in intensity.

Dr. Durnin and Dr. Ehmke are assistant professors of pediatrics, and Dr. Flege is a former staff member in the Division of Thoracic Surgery at the U. of I. College of Medicine. Reprint requests should be addressed to Dr. Durnin.

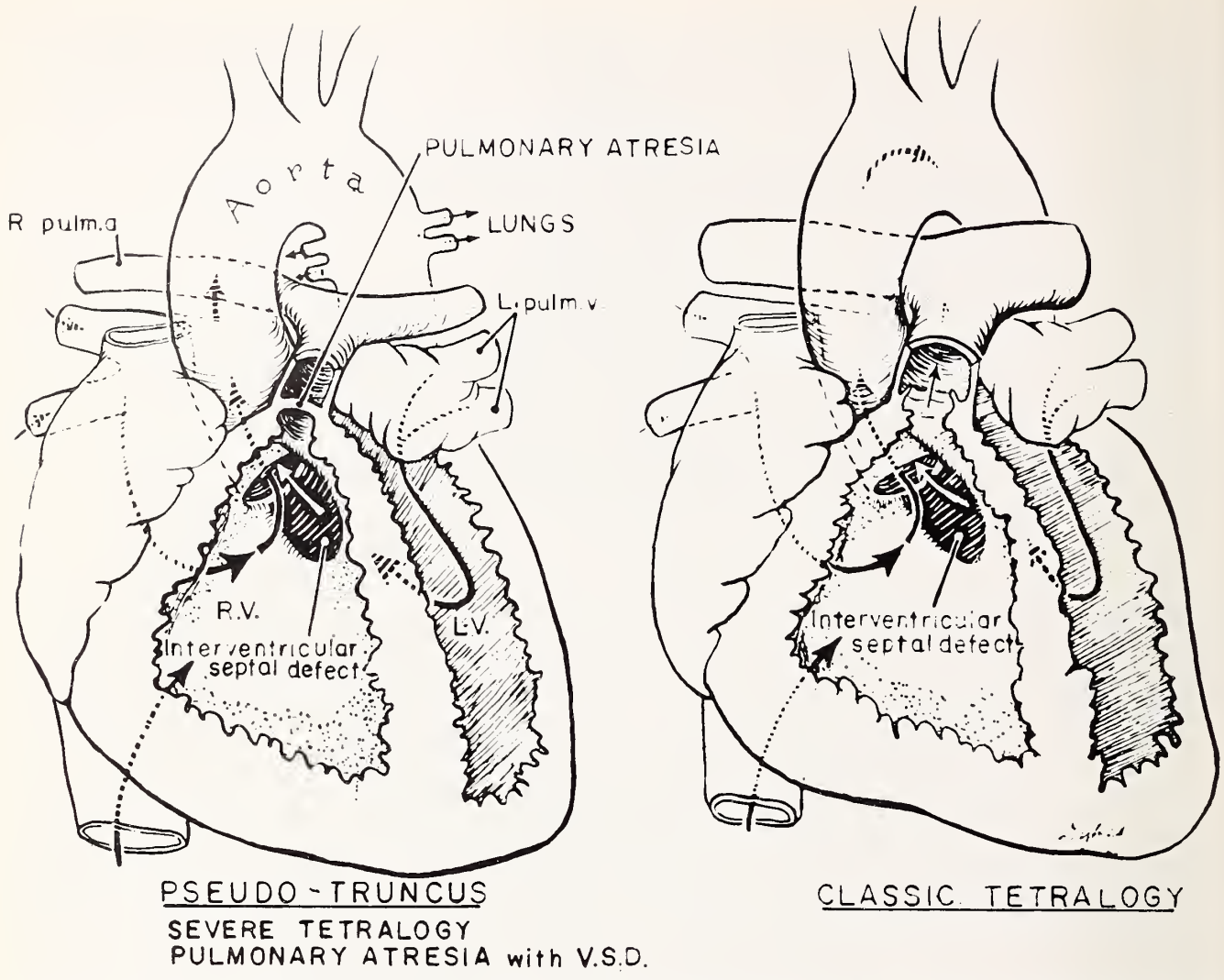


Figure 1. Anatomy of tetralogy of Fallot. The drawing on the right illustrates the classic tetralogy—with infundibular stenosis, a large ventricular septal defect and moderate dextroposition of the aorta. The diagram on the left illustrates the severest variant—with pulmonary valve atresia and hypoplastic pulmonary arteries. Pulmonary blood flow is via bronchial arteries arising from the descending aorta.

The electrocardiogram uniformly shows right-axis deviation and right-ventricular hypertrophy (Figure 2), reflecting the increased work load of the right ventricle. The chest roentgenogram shows that the heart size is normal or minimally enlarged (Figure 3). The pulmonary vascular markings are normal or diminished. The aortic arch is on the right in 25 per cent of cases.

Cardiac catheterization and angiocardiography are the definitive means for establishing the diagnosis of tetralogy of Fallot. Cardiac catheterization is routinely carried out on all cyanotic infants in whom this diagnosis is suspected. Angiographic studies will demonstrate simultaneous opacification of the aorta and pulmonary artery, and the ventricular septal defect, and thus will outline the infundibular or valvular pulmonic stenosis (Figure 4).

The management of tetralogy of Fallot is both medical and surgical. The ultimate endpoint in the management of children with this lesion is correction of the intracardiac defects. These children are subject to certain complications which influence their management, namely hypoxic spells, brain abscess, bacterial endocarditis, polycythemia, bleeding tendencies, and pulmonary and cerebral thrombosis. Congestive heart failure in isolated tetralogy is uncommon.

Hypoxic spells or attacks of paroxysmal dyspnea occur in 40 per cent of infants with tetralogy.[5] The peak incidence is in infants between one and three months of age. The hy-

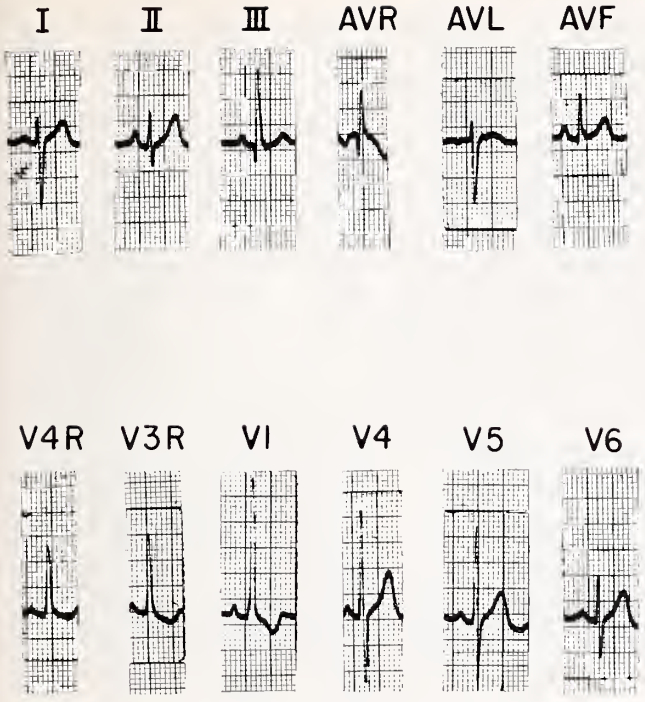


Figure 2. Electrocardiogram in a five-year-old with tetralogy of Fallot. There is right-axis deviation and right-ventricular hypertrophy (tall R waves in V_{4R}-V_1).

poxic spells are usually related to the severity of the disease, but some infants who are mildly cyanotic may have severe spells. During the hypoxic spells there is increased right-to-left shunting, with decreasing flow of blood to the lungs for oxygenation. Spells are characterized by tachypnea, increasing cyanosis and tachycardia. The infant may lose consciousness and have a seizure. Cerebral vascular accidents sometimes occur. During the spell, the clinically evident murmur decreases in intensity or is inaudible. The arterial oxygen saturation drops precipitously, and metabolic acidosis develops. Hypoxic spells may be fatal.

These attacks usually occur in the morning, and are precipitated by exertion, eating, stooling, crying or a Valsalva maneuver. Often the mother can terminate a hypoxic spell by placing the infant in the knee-chest position. Subsequently the infant will often sleep.

When an infant with tetralogy has a hypoxic spell, certain measures should be started immediately: 1. The infant should be given oxygen by mask. 2. If the infant is restless, morphine (0.05 to 0.1 mg./lb.) or Phenergan (4 to 6 mg.) is given intramuscularly. If the patient is restful, no sedation is indicated. 3. Blood-gas analysis is done immediately to determine the

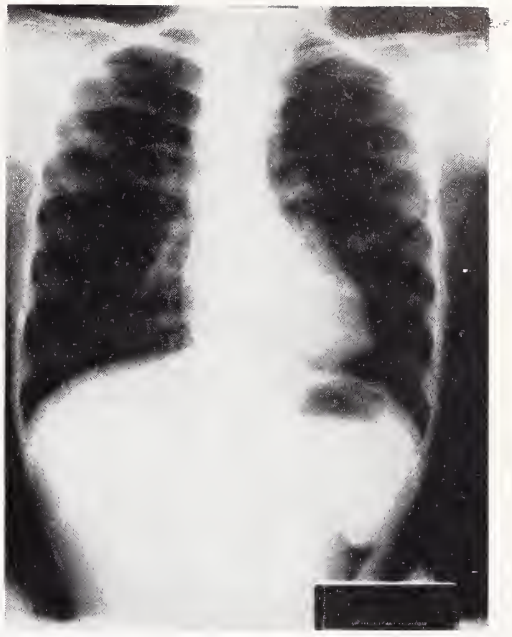


Figure 3. Chest roentgenogram shows the heart size to be normal. There is elevation of the cardiac apex secondary to right-ventricular hypertrophy. The aortic arch is right-sided. The pulmonary vascular markings are diminished.

degree of metabolic acidosis, and $NaHCO_3$ (1 mEq./Kg.) is given intravenously immediately. The blood gases are rechecked in a half hour to an hour, and further $NaHCO_3$ is given until the metabolic acidosis has been corrected. 4. Intravenous fluids (1,500 cc./M^2/ day) in the form of ⅕ normal saline, are begun. Potassium chloride is added after the infant has voided. 5. Serum-electrolyte concentrations and the complete blood count should be determined immediately. A booster transfusion of sedimented red cells is given if the hemoglobin is less than 12 Gm. Although a hemoglobin of 11 to 12 Gm. is adequate for a normal infant, such a level indicates a relative anemia in an infant with serious cyanotic congenital heart disease. Not infrequently, hypoxic spells occur in the presence of anemia. Most spells can be terminated by appropriate therapy. 6. Digitalis therapy is usually contraindicated. Surgery is indicated for hypoxic spells.

Brain abscess[6] is an infrequent complication in tetralogy, and it usually is not seen in infants less than two years of age. This diagnosis should be strongly considered if there is fever, with neurologic signs and symptoms. Brain abscess requires immediate surgical consultation.

Bacterial endocarditis should be considered if there is unexplained fever, or continued fever after antibotic therapy for a respiratory in-

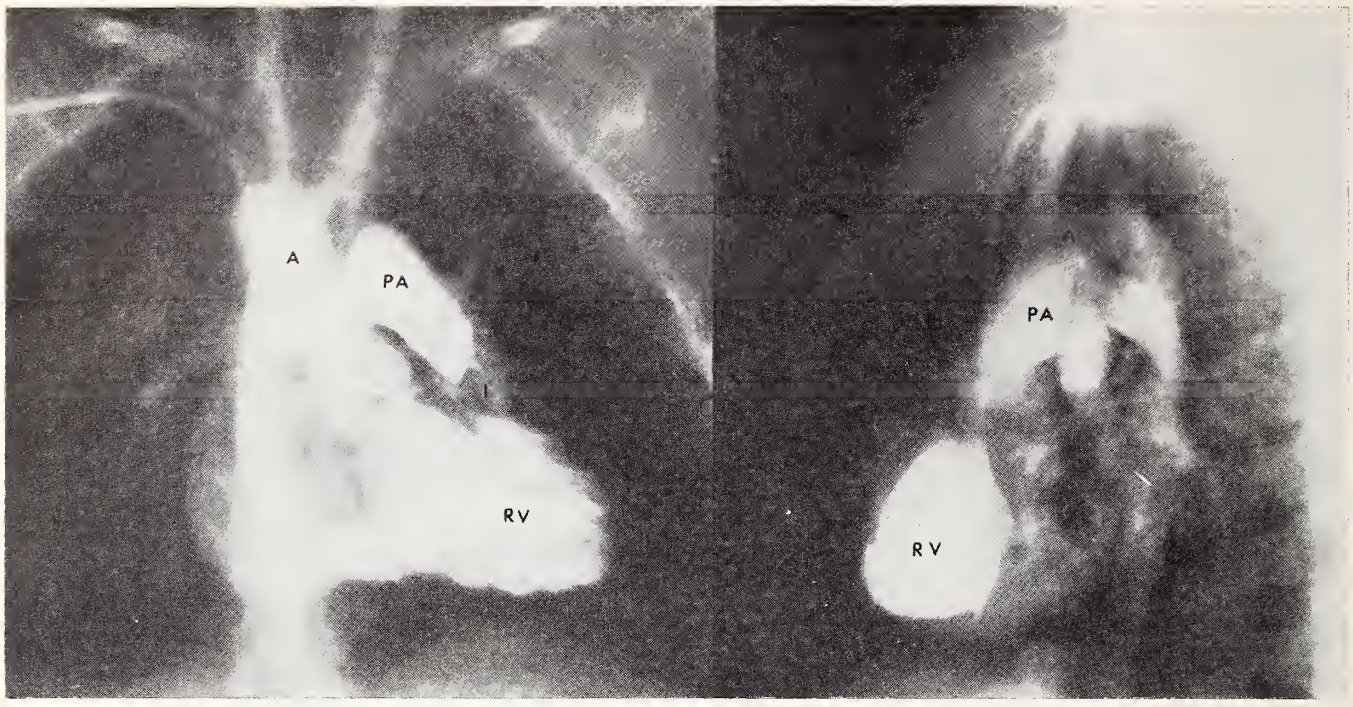


Figure 4. Angiocardiogram. Injection of contrast material into the right ventricle (RV) shows simultaneous opacification of the aorta (A) and pulmonary arteries (PA). The aorta fills from right to left, shunting through the ventricular spetal defect. The aortic arch is right-sided. There is infundibular stenosis (I).

fection.[6] To prevent bacterial endocarditis, antibiotic therapy is indicated for respiratory infections, elective dental procedures and surgical procedures.

Because of the chronic hypoxia, polycythemia is common. There is a tendency for thrombosis to occur at hematocrit levels in excess of 75 per cent. For that reason liberal fluid intake is advised during febrile illnesses, during warm weather and during episodes of diarrhea. Bleeding tendencies have been observed, and may complicate overall management. In adolescence, hemoptysis may occur secondarily to pulmonary thrombosis.

Surgery is indicated for infants who have hypoxic spells and extreme polycythemia,[7] or in small children who are markedly limited in their activities. Palliative surgery increases the pulmonary blood flow by means of an anastomosis (shunt procedure) between a systemic artery and a pulmonary artery, or by relieving the pulmonic stenosis. These operations are designed to alleviate the symptoms, to enhance the child's growth, and in the case of an infant, to prevent further hypoxic spells.

Three anastomotic or shunt procedures are commonly used (Figure 5): (1) Blalock-Taussig; (2) Potts-Smith;[8] and (3) Waterston.[9] The Blalock-Taussig shunt is an anastomosis between the subclavian artery and the pulmonary artery. In tiny infants the subclavian artery frequently is too small for an anastomosis, but in older infants and children it is quite satisfactory. The Potts-Smith anastomosis is made between the descending aorta and the pulmonary artery, and it produces a satisfactory shunt in infants but is very difficult to manage at the time of the subsequent definitive operation. The Waterston shunt is a side-to-side anastomosis between the ascending aorta and the right pulmonary artery, and it is the easiest anastomosis to perform on small babies. This shunt is readily closed at the time of definitive surgery. Following the completion of a successful anastomosis, a continuous murmur is noted clinically. If the anastomosis is too large, cardiac failure may ensue; if it is too small, symptoms will not be relieved, or the vessel may become occluded.

The fourth palliative procedure is the Brock operation[10] (Figure 5). In it, the pulmonary valve is opened, or the obstructing muscle in the right ventricular outflow tract is removed by means of instruments inserted through the wall of the right ventricle. Upon relief of the obstruction, there will be an increase in the flow of blood to the lungs, and the systolic ejection murmur will grow louder. If the relief of

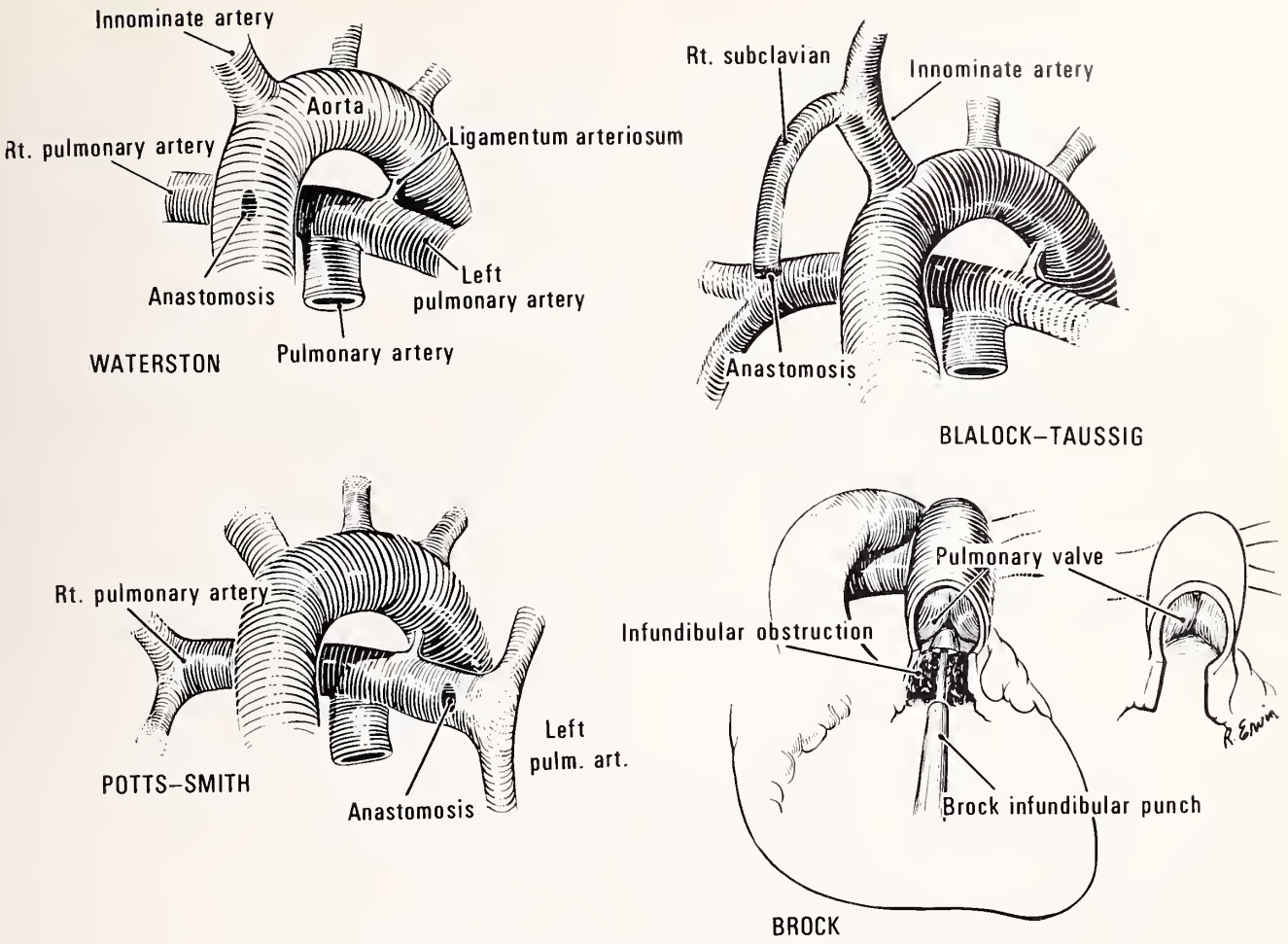


Figure 5. Palliative operations for tetralogy of Fallot.

obstruction is too generous, cardiac failure may ensue because the intracardiac shunt becomes left-to-right.

Total correction of tetralogy of Fallot consists of closure of the ventricular septal defect and relief of the pulmonic stenosis.[10] This definitive operation is a major undertaking, and requires total cardiopulmonary bypass, temporarily. The operation normally carries a low mortality, however, and a good hemodynamic result is to be anticipated. Some factors diminish the likelihood of surgical success, the principal ones being the patient's small size, an unfavorable anatomy of the right ventricular outflow tract, and associated anomalies. A patient less than four years old and smaller than average for that age is not a suitable candidate for definitive surgery. A patient of any age who has extreme hypoplasia of the right ventricular outflow tract or pulmonary arteries is a poor subject for total correction. Each case, however, must be individualized.

At operation, the ventricular septal defect is closed by means of a synthetic or pericardial patch. It is essential to avoid injuring the elements of the cardiac conduction system which are located along the inferior margin of the ventricular septal defect. One relieves a right-ventricular outflow obstruction by excising the obstructing tissue from the infundibulum, or performing a pulmonary valvulotomy. If this does not produce an adequate channel, one must widen the outflow tract by inserting a gusset of pericardium or synthetic fabric. A normal life expectancy can be anticipated for the child who has had a technically good repair.

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Neurologic Abnormalities Complicating Severe Renal Disease

ROBERT L. RODNITZKY, M.D.
Iowa City

THE APPEARANCE of neurologic symptoms in association with renal disease is not uncommon and has long been accepted. In 1839 Thomas Addison described five categories of cerebral dysfunction which might afflict patients with kidney disease.[1] His list included: (1) dullness of the intellect, sluggishness of manner, drowsiness, giddiness, dimness of sight and headache; (2) quiet stupor; (3) coma; (4) convulsions; and (5) coma with convulsions. Since Addison's report many additional neurologic sequelae have been described, and there has been an appreciable enhancement of our understanding of the symptoms that he listed. This review will describe the more common neurologic signs and symptoms found in patients with severe renal disorders. Additionally, the neurologic symptoms found in patients undergoing artificial dialysis will be discussed.

UREMIC ENCEPHALOPATHY

Among the neurologic complications of severe renal disease, uremic encephalopathy is probably the most striking. Clinically, it resembles many other types of metabolic encephalopathy. The syndrome is seldom precipitous in onset; rather, it progresses through stages of drowsiness, lethargy and confusion before more serious signs appear.[14] In some patients, however, irritability, insomnia, delirium and inappropriate behavior predominate, rather than lethargy.[6] If the underlying condition is not relieved, stupor or coma then prevails. During this advanced stage, focal neurologic signs and convulsions are common.

Although the focal signs do not form pathognomonic symptom complexes, there are several characteristic features which can aid the clinician. Pupillary responses and oculomotor functions are seldom altered in uremia.[16] Motor function, on the other hand, is commonly involved in one way or another. Generalized weakness is a common early complaint. Later one may see discrete monoplegias or hemiplegias, with hyperreflexia in the involved limbs. Additionally, there is often generalized neuromuscular irritability, with wrist-flapping tremor (asterixis), entensor plantar responses and muscle twitching. Myoclonic jerking, either focal or multifocal, appears in advanced cases, and frequently precedes generalized convulsions. Seizures occur in a significant percentage of uremic patients. Generalized seizures are more common than focal ones, but on occasion a typical Jacksonian march may be seen.

In addition to these commonly encountered signs of cerebral dysfunction, cerebellar signs including nystagmus, ataxia, intention tremor and scanning speech may result from uremia. An aseptic meningitis syndrome, with nuchal rigidity and as many as 250 mononuclear cells in the spinal fluid, can also be encountered.[18]

Dr. Rodnitzky is a resident in the Department of Neurology at the U. of I. College of Medicine. This work was supported by training grant NB-5007 of the National Institute of Neurologic Diseases and Stroke.

Electroencephalographic abnormalities are usually present in patients with uremic encephalopathy.[10] Characteristically, the EEG demonstrates: (1) a slowing of background activity; (2) occasional bursts of bilaterally synchronous slow waves; (3) abnormal arousal responses precipitated by noise, eye opening or photic stimuli; and (4) myoclonic responses to photic stimuli. It should be noted that electroencephalographic findings cannot be used alone to make the diagnosis of uremic encephalopathy, since similar changes occur in other metabolic encephalopathies.

One condition that frequently exists in patients with renal disease and which can be confused with uremic encephalopathy is hypertensive encephalopathy. Because this life-threatening condition requires prompt antihypertensive therapy, it must be clearly differentiated from uremic encephalopathy. Each condition can cause seizures, focal neurologic signs, increased intracranial pressure and alterations of consciousness. In a patient who is both uremic and hypertensive, it may be difficult to decide which condition is the source of neurologic symptoms. Several important points help to differentiate the two conditions:[16] (1) Uremia seldom causes rapidly fluctuating or transient neurologic signs, but rapidly changing signs are common in hypertensive encephalopathy. (2) Uremia alone seldom causes papilledema, cortical blindness, aphasia or increased cerebrospinal-fluid protein, whereas hypertensive encephalopathy may produce any or all of these. (3) Except in rare instances the blood urea nitrogen is significantly increased (above 100 mg. per cent) in uremic encephalopathy, but it may or may not be elevated in hypertensive encephalopathy. (4) The blood pressure is usually markedly elevated (above 120 mm. Hg diastolic) in hypertensive encephalopathy, although it may drop to normal levels soon after an acute attack. In uremia alone, such marked hypertension is less consistently found.

Although the clinical features of uremic encephalopathy have been thoroughly documented, its pathogenesis is not known. Most experimental evidence does not support the concept that the increased blood level of urea itself is the etiologic agent in this disorder. For instance, the infusion of exogenous urea into experimental animals does not produce encephalopathy. It is also known that hemodialysis improves the neurologic status of uremic patients, even when the level of blood urea itself is not lowered by the procedure.[15] Since the neurologic symptoms are almost always improved by dialysis, it has been postulated that the encephalopathy is caused by a dialyzable toxin of small molecular size. Some attention has been drawn to a group of organic acids which accumulate in uremic serum and which can be recovered from the dialysate.[5, 19] These organic acids are capable of inhibiting brain enzymes when incubated *in vitro*.[9] In health, such acids are presumably excluded from the brain and cerebrospinal fluid. It has been shown that in uremia, however, there is a non-specific increase in brain permeability[7] so that ordinarily excluded toxins may gain entry.

ELECTROLYTE DISTURBANCES

Electrolyte abnormalities frequently attend renal disease, and can produce neurologic symptoms independently.[8] Some of the most frequently encountered ones of these will be discussed.

Magnesium. In many cases of renal insufficiency, the serum magnesium is elevated, but not enough to cause neurologic symptoms.[23, 24] In some patients, however—particularly those taking magnesium-containing antacids, anticonvulsants or laxatives—the serum magnesium can be remarkably high. The symptoms of hypermagnesemia are primarily those of nervous-system depression. The first signs are sluggishness, somnolence and generally decreased responsiveness. Generalized weakness may ensue, and the deep tendon reflexes are lost when the serum level reaches 10 mEq. per liter. Coma may occur at levels of 12 to 15 mEq. per liter. Ultimately there may be respiratory paralysis (15 mEq. per liter). Since the mean serum-magnesium level among uremic patients not receiving magnesium-containing compounds is between 2 and 3 mEq. per liter,[8, 20] one can usually prevent these complications by avoiding administering such preparations.

Calcium. The serum calcium in uremia may be elevated, normal or low. Hypocalcemia is most frequent.[8, 18] In many uremic patients, concurrent acidosis tends to ionize a greater percentage of available calcium, but it is doubtful that this alters the neurologic symptomatology of significant hypocalcemia. The first signs

to appear are those of generalized neuromuscular irritability.[16] Tetany and a positive Chvostek sign may be seen. This sign may be elicited by tapping over the point of emergence of the facial nerve anterior to the ear. Contraction of any of the muscles supplied by the facial nerve constitutes a positive response. On occasion, the response can be elicited by merely stroking in front of the ear. Convulsions are quite common in hypocalcemia, so one must keep this condition in mind when he is dealing with uremic patients who are having seizures. Impaired function of the posterior and lateral columns of the spinal cord mimicking cord compression has been reported.[13] In addition, papilledema and increased intracranial pressure or so-called "pseudotumor cerebri" occasionally is seen.[16] It should be noted that if the hypocalcemia has developed very slowly, severe signs of neuromuscular dysfunction may be absent, and the patient may present with only a mild, diffuse encephalopathy.

Potassium. Potassium levels can be either depressed or elevated by renal disease.[8, 18] In general, patients with renal shutdown or severe renal insufficiency suffer from potassium retention. Other renal disorders such as the DeToni-Fanconi syndrome, tubular acidosis and other "salt-losing" nephropathies result in low serum-potassium levels. Neurologic signs due to hypokalemia occur only irregularly.[2] There may be a flaccid paralysis of muscles, presumably due to hyperpolarization of muscle membranes. Prolonged paralysis is also seen after the administration of curare-type drugs. Confusional states and coma can occur, but probably only when there is concurrent acidosis, alkalosis or dehydration.

Hyperkalemia can also cause flaccid paralysis of muscle, but in this case it is thought to be due to prolonged depolarization of muscle membranes. Excess potassium can rarely cause muscle hyperirritability and, on occasion, peripheral paresthesias. Mydriasis has also been observed in hyperkalemia.

Sodium. Serum sodium may be elevated or depressed in renal disease.[18] Hypernatremia is the least serious neurologically. The resultant clinical condition is usually an encephalopathy with signs of delirium rather than of coma.[16] Hyponatremia, on the other hand, is more common and potentially more serious. Most often it results from excess renal-sodium loss, overhydration or shifting of sodium from the extracellular compartment into the cells.[18] The early symptomatology of hyponatremia includes confusion, fatigue, headache, nausea, vomiting and anorexia. If the serum sodium does not fall below 120 mEq. per liter, there may be nothing more than these mild generalized signs.[16] If the level falls below 110 mEq. per liter, one can expect more severe symptoms, including bulbar palsy, stupor, myoclonus and generalized seizures with prolonged postictal coma.[4, 16] The symptom complex closely resembles that of uremic encephalopathy, and the latter condition must be considered in any uremic patient with encephalopathy or convulsions. It should be noted that hyponatremia is not restricted to disorders of renal function. A similar syndrome can be produced by a host of other conditions including inappropriate antidiuretic-hormone secretion, compulsive water-drinking and Addison's disease.

NEUROPATHY

Peripheral neuropathy is an important complication of renal disease.[3, 11, 17, 21, 22] It is particularly prominent in patients with severe chronic renal failure.[6, 21] The neuropathy is predominantly distal, symmetrical and mixed (motor and sensory). The first symptoms are burning sensations in the feet, followed by numbness and paresthesias. The feet and legs are usually more affected than the upper extremities. Eventually, the neuropathy may lead to unsteadiness in walking and to weakness. In uremic neuropathy, in contrast to diabetic neuropathy, the cranial and autonomic nerves are seldom involved.[21] Microscopic examination of affected nerves has revealed non-inflammatory destruction of axis cylinders and myelin sheaths.[3] The specific metabolic derangement responsible for uremic neuropathy is unknown. Levels of blood urea nitrogen, calcium, phosphorus, magnesium and creatinine have not correlated well with the occurrence of clinical neuropathy or with a decrease in nerve conduction velocities.

When artificial dialysis was first started, an increased incidence of neuropathy in uremic patients was noted. Dialysis, itself, was at first thought responsible. Shortly, however, it was noted that patients receiving dialysis at the

usual frequency experienced worsening neuropathies, whereas those dialyzed more frequently than was usual at that time showed improvement, even though it was thought that both groups were being treated adequately from a chemical standpoint. Clearly, dialysis that is adequate by chemical standards is not always sufficient to prevent or to arrest the development of neuropathy. The progression or worsening of neuropathy is now recognized as a highly sensitive index of the adequacy of the dialysis program. In many centers, nerve conduction velocities are routinely followed as guidelines to the efficacy of dialysis.[11] With continued dialysis, a remarkable reversal of neuropathy can be effected.[21] Successful renal transplantation is even more effective in this regard. If, however, there is progression past a certain stage of severity, improvement may be limited.[6]

COMPLICATIONS OF DIALYSIS

A condition known as dialysis dysequilibrium can develop during rapid diuresis, peritoneal dialysis or hemodialysis. It is related to the rapidity of change in serum osmolarity, and therefore it occurs most frequently during hemodialysis.[22] When the blood-urea level is reduced rapidly during dialysis, the decline in brain-urea level lags behind, and an osmolar gradient is set up between blood and brain. Water enters the brain and produces cerebral edema. Then signs of brain dysfunction become apparent. One can prevent a disparity between blood and brain osmolarity by adding hypertonic glucose or urea to the dialysis bath,[12] or more simply by dialyzing less rapidly.

The neurologic symptoms of dialysis dysequilibrium may at first be non-specific and mild.[22] Early during hemodialysis the patient may appear sleepy and inattentive. Later he may become irritable and restless, and experience headache, nausea and vomiting. If dialysis is continued, the blood pressure may rise, and then fasciculations, twitching and asterixis may appear. With continuation of the procedure, there may be convulsions and, ultimately, coma.

Along with clinical deterioration during rapid dialysis, there are electroencephalographic changes.[12] Against the background of the usual changes seen in uremic encephalopathy, high-voltage rhythmic delta waves develop. These changes, like the clinical deterioration, one can prevent by adding hypertonic glucose or urea to the rinsing fluid.

SUMMARY

1. Neurologic symptoms are commonly found in patients with advanced renal disease. Uremic encephalopathy, one of the most striking complications, is probably unrelated to blood-urea levels, but can be reversed successfully by dialysis.

2. Hypertensive encephalopathy must be clearly differentiated from uremic encephalopathy. There are several clinical and biochemical features which help one distinguish between the two syndromes.

3. The renal electrolyte abnormalities which can cause neurologic symptoms are hypermagnesemia, hypocalcemia, hyponatremia, hyperkalemia and hypokalemia. The resultant neurologic symptoms can usually be reversed by a restoration of the electrolyte balance.

4. Neuropathy occurs in severe chronic renal disease. Like uremic encephalopathy, it is thought to be unrelated to blood-urea levels, but it is responsive to dialysis.

5. If performed too rapidly, the process of dialysis itself can cause significant brain swelling, and produce the dialysis dysequilibrium syndrome.

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Possible Traumatic Rupture of Aortic Valve, Bacterial Endocarditis and Bilateral Coronary Embolism

GERALD J. SHIRK, B.S., and
MICHAEL E. KORNS, M.D.
Iowa City

TRAUMATIC RUPTURE of the aortic valve is uncommon.[1] Unilateral coronary arterial or arteriolar embolism is probably not as rare as is commonly supposed. On the other hand, instances of occlusive emboli of the proximal segments or ostia of both coronary arteries are rare. In the case to be reported here, it is thought possible that there was traumatic rupture of a normal aortic valve. Subsequently, the damaged valve became the seat of bacterial endocarditis, and the vegetations gave rise to emboli which occluded the ostia of both coronary arteries.

Mr. Shirk is a senior medical student and Dr. Korns is an assistant professor of pathology at the U. of I. College of Medicine. This work was supported in part by a grant from the Iowa Heart Association. Requests for reprints should be addressed to Dr. Korns.

CASE REPORT

A 17-year-old, mentally retarded white woman was admitted to University Hospitals on March 25, 1969, because of severe, unremitting congestive heart failure postpartum.

At about the time that she became pregnant she was said to have received several severe beatings. During the seventh month of her pregnancy and three weeks before her admission to University Hospitals, she had been admitted to a local hospital with a cough and shortness of breath. Physical examination at that institution showed systolic and diastolic murmurs, gallop rhythm, tachycardia and edema of the ankles. She was treated with digitalis, diuretics and antibiotics. Labor was induced and she was delivered without complications. Postpartum, however, she had increasing shortness of breath, the onset of chest pain, and severe dysphagia.

Physical examination at the time of her admission to University Hospitals showed that the patient had moderate respiratory distress, with cyanotic lips and fingernails. The blood

pressure was 148/40/0 mm. Hg. The arterial pulses were of large volume and celer contour. A grade III/VI harsh, blowing systolic ejection murmur was heard at the second intercostal space on the left, and there was a grade III/VI blowing diastolic murmur along the left sternal border. There were basilar rales in both lungs. The liver was enlarged.

Laboratory Data. The urine was normal. The hemoglobin was 10.2 gm. per cent; the hematocrit, 32 per cent; and the leukocyte count, 15,500/cu. mm. Six of seven blood cultures were sterile; the seventh showed *Staphylococcus epidermidis.* Roentgenograms of the chest showed enlargement of the heart, principally of the left atrium, and pulmonary vascular congestion. An electrocardiogram showed digitalis effect. Angiocardiograms were interpreted as showing massive aortic insufficiency and slight mitral insufficiency.

The patient had no fever, but continued to have nausea and vomiting, dysphagia and pain in the chest. It was planned to replace the aortic valve with a prosthesis on April 16, 1969, but the patient died suddenly eight hours before the operation was to have started.

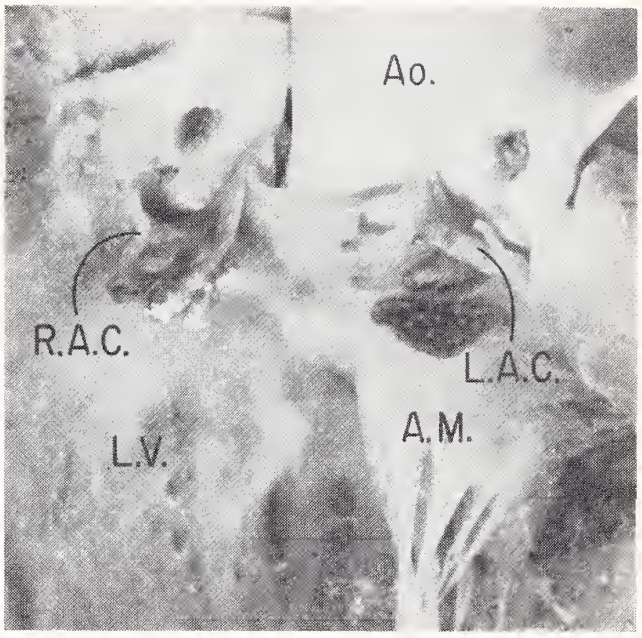


Figure 1. Aorta (Ao.), aortic valve, and left ventricle (L.V.). The right aortic cusp (R.A.C.) and the left aortic cusp (L.A.C.) are covered by vegetations, and much of both cusps has been destroyed. Plaque-like vegetations extend onto the ventricular surface of the anterior mitral leaflet (A.M.). The posterior aortic cusp contains a perforation. Above the right and left aortic cusps, respectively, the ostia of the right and left coronary arteries are occluded by emboli from the adjacent vegetations.

NECROPSY

Necropsy was done nine hours after death. The principal abnormalities involved the cardiovascular system. The pericardial sac contained 60 ml. of serous fluid, and there was fibrinous exudate on the epicardium. The heart weighed 360 gm. The aortic valve had remnants of three cusps, two of which were covered by verrucous, friable, black and gray vegetations (Figure 1). Plaque-like vegetations extended from the aortic valve onto the ventricular surface of the anterior mitral leaflet. The noncoronary cusp contained a perforation, but there were no vegetations. On the other hand, the right and left aortic cusps had been virtually destroyed; the remnants of these cusps were ragged and small. The ostia of both coronary arteries had been occluded by emboli from the vegetations. Both papillary muscles of the left ventricle had a mottled yellow appearance. The left atrium was dilated, and there was diffuse thickening of the endocardium. No jet lesions were seen. The right ventricle was moderately dilated. The other valves were normal.

Bilateral plural effusion, acute pulmonary edema, centrolobular hepatic necrosis, and severe, generalized visceral stasis were regarded as manifestations of congestive heart failure.

Histologically, a recent embolus occluded the proximal segment of both coronary arteries. The emboli contained fibrin, platelets, calcium, a few foreign-body giant cells, and irregular islands of organizing fibrous tissue, but no bacteria. The emboli were similar to the vegetations and were not adherent to the walls of the coronary arteries, which were normal. Cultures of the vegetations showed *Bacterium antitratum* which was regarded as a contaminant. Sections from both papillary muscles showed miliary acute infarcts, and there were several foreign-body giant cells in juxtaposition to arterioles (Figure 2).

COMMENT

One or more of the aortic leaflets may be torn as a result of nonpenetrating trauma of the thorax, or the valve may rupture spontaneously—i.e., apparently without trauma of any sort.[1-3] Nontraumatic spontaneous rupture of the aortic valve usually occurs when the valve is abnormal as a consequence of either con-

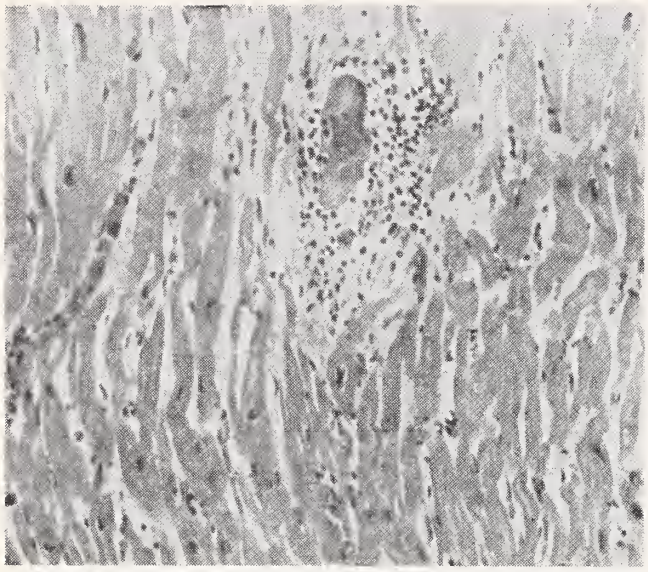


Figure 2. Posteromedial papillary muscle of left ventricle. Interstitial foreign body granuloma as a consequence of arteriolar embolus. (Hematoxylin and eosin, X120.)

genital or acquired disease, or both. Howard showed that the aortic valve was normal in 44 per cent of the cases of traumatic rupture.[1] Rupture of the aortic valve may ensue either from a focal injury to the thoracic cage or from a diffuse, uniform increase in pressure on this structure. The increase in aortic pressure during diastole brings about a tear of an aortic leaflet, of the adjacent aortic intima, or both.[2]

Bacterial endocarditis may involve a normal cardiac valve, but this is not the usual circumstance. On the other hand, a valve which is abnormal, for whatever reason, commonly becomes the seat of infectious endocarditis.[4]

Coronary embolism from vegetative endocarditis of the aortic valve may readily occur because of the proximity of the vegetations to the coronary ostia, and because of the friable nature of the vegetations. It is rare, however, that occlusive emboli involve the ostia of both coronary arteries.

In this case there were no stigmata either of acquired disease such as rheumatic endocarditis or of a congenital anomaly such as a bicuspid aortic valve. In view of the history of trauma and because of the fact that a normal valve uncommonly becomes the seat of infectious endocarditis, it seems most likely that the aortic valve was ruptured by trauma. Subsequently, bacterial endocarditis occurred. Most of the valve was destroyed and, consequently, there was severe aortic insufficiency. This and the increased cardiac load imposed by pregnancy led to severe, unremitting congestive heart failure. Sudden death occurred when the ostia of both coronary arteries were plugged by emboli. The minimal degree of mitral insufficiency was probably caused by dysfunction of the papillary muscles which, in turn, was caused by previous emboli.

SUMMARY

A case of presumptive traumatic rupture of the aortic valve has been presented. The sequelae were bacterial endocarditis, aortic insufficiency, embolic occlusion of both coronary ostia and sudden death.

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Meeting of the

IMS
NOMINATING COMMITTEE

2:00 p.m., Sunday, March 22

IMS Headquarters Building

West Des Moines

Meetings of the Nominating Committee are open to all members of the IMS in good standing, except when the Committee goes into executive session.

Peripheral Blood Response to Thyrotoxicosis

D. L. LANDSTROM, M.D.,
H. E. HAMILTON, M.D., and
R. F. SHEETS, M.D.
Iowa City

Considerable attention has been focused upon hematopoietic changes associated with thyrotoxicosis. Sattler, in his classic treatise, mentioned the anemia, lymphocytosis and leukopenia of Basedow's disease, and referred to studies in the literature *circa* 1900.[1] Subsequent authors concerned with thyrotoxicosis have also mentioned anemia, leukopenia, lymphocytosis and monocytosis.[2-6] It is unclear to what extent such changes can be expected, and to what degree they form a primary portion of the condition as opposed to being secondary manifestations of intercurrent disease processes.

In recent years there have been a number of sophisticated studies in both man and animals with findings of increased erythropoiesis,[7] accelerated red-cell production,[8] decreased red-cell survival,[9] normal red-cell survival,[10, 11] increased total red-cell volume,[8, 12] increased plasma iron clearance, increased red blood cell iron utilization, increased plasma iron turnover,[13] and impaired gastric-acid secretion.[14]

The present study deals with the case records of 107 thyrotoxic patients successfully treated with radioactive iodine. It is directed to the question of whether clinically- and/or diagnostically-significant changes occur in the cellular elements of the circulating blood of thyrotoxic patients, and it attempts to quantitate any such changes.

Dr. Landstrom, when he wrote this paper, was a medical intern at University Hospitals, Iowa City. Dr. Hamilton and Dr. Sheets are professors of internal medicine at the U. of I. College of Medicine. Reprint requests should be addressed to Dr. Hamilton.

PATIENTS AND METHODS

Patients receiving radioactive iodine therapy at the University of Iowa Hospitals are followed in a thyroid clinic, and are presented at regular intervals to an interdepartmental thyroid conference.

The case records of 57 female and 50 male patients were obtained from the clinic files. The mean age for women was 45 years, and that for men was 42 years. The mean estimated duration of toxicity was 21 months for both groups. The disease was classed as mild in 20 cases, moderate in 70 cases, and severe in 17 cases. Case records were excluded from the study only because of (1) incomplete data; (2) coincident neoplasm; (3) documented pernicious anemia; or (4) coincident disorders involving blood loss other than menstrual irregularities. Thyrotoxicosis and euthyroid state were diagnosed on the basis of repeated clinical assessments by the thyroid conference, and were supported by appropriate laboratory tests including protein-bound iodine, I^{131}-uptake, basal metabolism rate, red-cell T^3-uptake and serum cholesterol.

The following procedures were identical for all parameters investigated: hemoglobin, hematocrit, and total white-blood-cell and differential counts. In each individual case two statistical means were available. The first of them represented all values during the thyrotoxic state, and the second represented all values obtained while the patient was euthyroid. The individual means were then averaged for the male and female groups to produce corresponding group means. The degrees of significance of the differences between these two means were then determined. Similar computations were

TABLE I

	Hb	Hct	WBC	L%	S%	M%
Men						
Toxic	14.1	45.6	8,245	34	57	6
Euthyroid	14.8†	47.2	8,835‡	32	61‡	4†
Number	47	18	50	41	41	41
Women						
Toxic	13.2	42.0	7,516	33	60	5
Euthyroid	13.6†	43.2‡	7,919	29‡	64	4
Number	55	36	55	50	50	50

† $p < .01$
‡ $p < .05$
L = Lymphocytes
S = Polymorphonuclear leukocytes
M = Monocytes

performed upon each of the three severity subgroups. In addition, we calculated coefficients for the study group as a whole, correlating both age and estimated duration of toxicity with the peripheral-blood changes.

RESULTS

The results are summarized in Table 1. The means that indicated statistically-significant differences between the thyrotoxic and the euthyroid states are indicated. All other changes were not significant.

Hemoglobin was the only parameter in which there were statisically-significant changes for both men and women. Figure 1 shows the distribution of the individual mean hemoglobin values for all the patients before and after treatment.

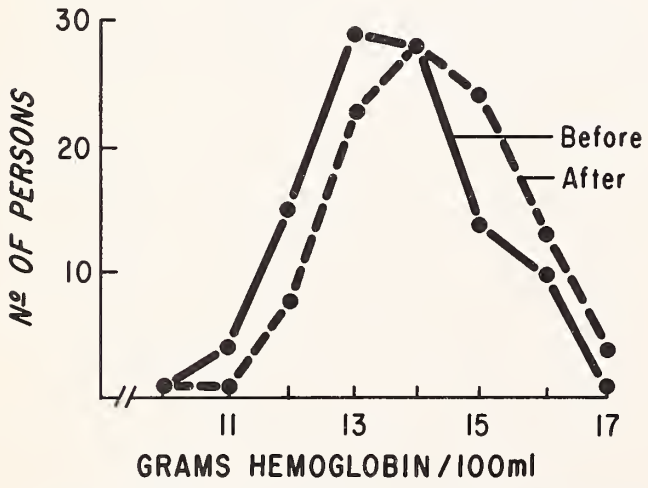


Figure 1. Distribution of mean hemoglobin values of 107 subjects before and after successful treatment of thyrotoxicosis.

Neither age nor duration of toxicity correlated significantly with changes in any parameter measured. No remarkable changes, in any instance, were dependent upon the degree of severity.

DISCUSSION

Table 1 shows that even the changes which were deemed statistically significant were not clinically relevant, and that all the mean values fell in the midsection of the range, as one would expect if he had tested a normal population. In the United States, the mean hematocrit level for men was 46.5 ml. per cent, and that for women was 42.4 ml. per cent.[15]

These data do not preclude the possibility that an occasional case of thyrotoxicosis may cause clinically significant changes in hemoglobin, hematocrit or white blood cell count. However the infrequency of such an occurrence would preclude its having any diagnostic import. We conclude, therefore, that although various hematopoietic changes may occur in thyrotoxicosis, they are well compensated and have little clinical significance. A corollary to this finding is that clinically-significant changes, when they do occur, should be presumed to be secondary to intercurrent disease, and should occasion the same concern and depth of investigation that they would prompt if they were found in a euthyroid patient.

SUMMARY

Averages were computed for the hemoglobins, the hematocrits, and the total white-cell and differential counts for a series of 107 thyrotoxicosis patients (1) before and (2) after successful therapy with radioactive iodine. These mean values fell within the range expected for a normal adult population. No clinically- or diagnostically-significant changes were found to have occurred during the thyrotoxic state. We further concluded that such changes—when they do occur—should be presumed due to intercurrent disease, and should occasion the same concern and depth of investigation that are accorded them in the euthyroid patient.

ACKNOWLEDGEMENT

We wish to thank Dr. Paul Leverton, of the U. of I. Biostatistics Department, for his assistance in this study.

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Fourteenth Annual Blank Hospital Pediatric Conference

The fourteenth Annual Blank Hospital Pediatric Conference, sponsored by the Raymond Blank Hospital Guild, the Division of Maternal and Child Health of the State Department of Health, and the Iowa Chapter of the American Academy of Pediatrics, will be held at the Iowa Methodist School of Nursing, 1100 Pleasant Street, Des Moines, on April 2 and 3, 1970.

Registration fee for the entire conference, including luncheons and one banquet ticket, is $30. Registration for one day (including luncheon) is $15. For interns and residents, the registration fee is waived.

Doctors' wives are encouraged to attend. Additional luncheon tickets are $2 and banquet tickets $6 each.

Thursday, April 2

9:15 a.m. "Intravascular Coagulopathy," the 14th Lee Forrest Hill Lectureship—Andre Lascari, M.D., U. of I. College of Medicine

10:30 a.m. "Practical Problem of Genetic Counseling" —Stanley W. Wright, M.D., UCLA Medical Center

11:15 a.m. "Intensive Care of the Neonatal Infant"— Richard E. Behrman, M.D., U. of Oregon Medical School

1:45 p.m. "Nutrition and the Developing Brain"—Phillip R. Dodge, M.D., Harvard Medical School

2:30 p.m. PANEL DISCUSSION: Neonatal Seizures
Lee Forrest Hill, M.D., moderator; Drs. Behrman, Dodge, Wright and Lascari; Case presentation by Raymond Blank Memorial Hospital house staff

4:00 p.m. "Disorders of the Diaphragm"—James Hopkins, M.D., Pediatric Surgeon, Des Moines

4:30 p.m. BUSINESS MEETING—Iowa Chapter, American Academy of Pediatrics

Friday, April 3

9:00 a.m. PANEL DISCUSSION: Neonatal Seizures
Lee Forrest Hill, M.D., Moderator; Drs. Behrman, Dodge, Wright and Lascari; Case presentations by Raymond Blank Memorial Hospital house staff

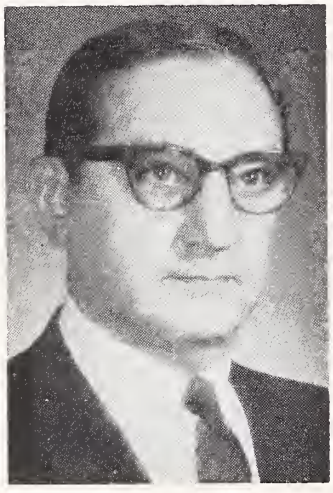
10:00 a.m. "Electrolyte Disorders Complicating Diarrhea"—Dr. Dodge

11:15 a.m. "Genetics of Common Malformations and Illnesses"—Dr. Wright

1:45 p.m. "The Intrauterine and Extrauterine Management of Asphyxia"—Dr. Behrman

2:30 p.m. "Current Chemotherapy of Malignant Tumors of Childhood"—Dr. Lascari

President's Page



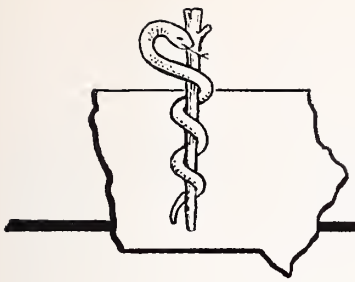
In this issue of the JOURNAL you have an opportunity to acquaint yourself with the full program for the forthcoming 1970 ANNUAL MEETING of the IOWA MEDICAL SOCIETY. As a personal favor, please take a minute to see what has been arranged.

To plan and arrange a program of this dimension is no small assignment. Considerable exhilaration and satisfaction are associated with this planning process; there is a formidable challenge in choosing interesting topics and securing capable speakers. I would like to pay personal tribute to those physicians who have worked diligently these past months preparing a meaningful scientific/socio-economic agenda for the 1970 ANNUAL MEETING. They have performed yeoman service.

Now it's up to the rest of us. Participation becomes the key. If the 1970 program is to be recorded as a success, we are the ones who will make it such. Please consider holding the period from April 26 to 29 open, and please try to arrange your practice so you can attend all or part of this 1970 Annual Meeting of your Iowa Medical Society.

Wm M. Kingsley MD

President



Editorials

LONG AND DISTINGUISHED SERVICE

It is with sadness that we announce the retirement of Edward W. Hamilton, the managing editor of the JOURNAL, on March the first. He has occupied this position since 1953 and has fulfilled the responsibility with distinction. He and his talents will be missed.

All of us who have worked with "Ed" and all whom he has served so well wish him many happy years of retirement, good health, and a multitude of interests and hobbies to enrich each day. May the succeeding years treat him kindly.

WHAT TROUBLES TROUBLED YOUTH

An article by Dr. Iago Galdston, of Brooklyn, New York, published in THE LANCET for November 29, 1969, deserves wide dissemination among physicians, parents, educators and, in fact, all people concerned with the problems of youth today. His article, entitled "What Troubles Troubled Youth," is an effort to explain "in the perspective of history" what has brought about, not a generation gap, or an alienation of youth, but rather a definitive break. The author asserts that youth of today are not alienated, for they never were committed. He declares that the older generation have lost their historical perspective and their nerve. The cause of youth's revolt cannot be ascribed to villainy or conspiracy, for it is not restricted to the United States. It is global, and is occurring in France, in Germany, in Russia and in England, among many other places.

According to Dr. Galdston, much of what we reap today can be ascribed to the technologic revolution and the development of an industrial society. Whereas for thousands of years man lived close to the soil or to the sea, the industrial revolution resulted in a cataclysmic social disorganization. One of its most disruptive effects was that which befell the homestead, the family, and the interrelationships of man, woman and child.

The author points out that the homestead, ideally, embraced three generations, and was an institution with a broad impact. Basically, it was a school for living wherein successive generations of youth were indoctrinated both by practice and by precept in the techniques and wisdom necessary to assure a good and useful life. For the older members of the household it offered security during advancing years. Such an enduring and continuing family organization inculcated the virtues of honest husbandry and good will.

As a consequence of the industrial revolution, the patriarchal family has undergone rapid disintegration, according to Dr. Galdston, and we now are experiencing the results of the rejection of the patterns and values and mores which constituted the foundations of our culture. He calls it socio-cultural delinquency. Sadly, society has found nothing permanent to take its place. "Religion and law, morals and discipline, are openly flouted and aggressively challenged. The humble virtues—those of

Editorials continued...

work, order, discipline, the fulfillment of pledge and promise, of judicious husbandry, neither niggardly and mean nor profligate and wasteful—have become trivial in the mood of our times."

He emphasizes that it is the demotion of the father that has disrupted the means and processes of ethos transmission which is at the core of the present-day historical crisis. The absent or ineffective father does not create the delinquent; he merely fails, or probably is not qualified, to indoctrinate his children effectively.

Dr. Galdston asserts that society is sick, and its morbidity is most clearly manifested in the family. Juvenile delinquency, divorce, alcoholism, drug addiction, homosexuality and frantic promiscuity—all these are widespread. But none is more terrifying than the anarchy of youth, wrongly called "juvenile delinquency." He objects to the term *juvenile delinquency* on the grounds that it implies a failure to fulfill an obligation or a duty. Such a failure presupposes that the individual knows and wilfully fails to meet that obligation. If the individual does not know his duties and obligations—know them in a compelling manner from a compelling conscience—how can he be looked upon as a delinquent?

The author contends that in the ideal family the developing child finds in the mother a source of nourishment, of comfort and of affection. It is the early, consistent and effective presence of the father within the family complex, his effective male relationship with the mother and his function as arbiter in matters of ethics, morals and social mores, which are of vital importance to the healthy psychologic growth and development of the child. Freud taught that the superego or conscience represents the incorporated father image.

As a consequence of the historic change in the family, the convictions belonging to previous generations have given way to an indecisiveness—a state of not knowing what to do and of not knowing what to think about the state of the world. This leads to a catastrophic change which initially is negative and critical. The individual knows, or rather thinks he knows, that traditional norms and ideas and ideals are inadmissable. But sadly, there are no positive beliefs with which to replace the traditional ones. It is at these times of crisis that false or feigned positions are widely adopted. A youth feels lost, and may respond with profound skepticism regarding life's values, with anguish or with desperation. He may do many things which he considers heroic, but which are but deeds of desperation. He may react with fury or with madness or in a spirit of vengeance because of the sheer emptiness and bitterness of life.

Dr. Galdston acknowledges that although the patriarchal ethos served past generations well, it is, in many of its elements, unsuited to present-day life, and in a confused world which is the product of technologic revolution. However there are elements of the patriarchal ethos which in human terms are eternal—truth, authenticity, charity, love, work and creativity. He declares that without these, man is not man, no matter what his economic or political state.

He concludes his paper with the statement: "I believe we of the older generation have failed our youth in not insisting, against all odds and all opposition, on the validity of these virtues. We need to stand firm on these elements of our own faith—even as did the father of the Prodigal Son. We need, I submit, to cultivate an historic perspective and to regain our nerve."

Even in agrarian Iowa, a state looked upon as the home of conservatism and of conservative people, manifestations of changing mores are disquieting and even alarming to thoughtful citizens. The crime rate has doubled in the state in the last six years. In our 14 largest cities the population has risen less than one per cent during this six-year period, but the actual numbers of crimes have increased by 84 per cent. In recent years there has been one divorce for every four marriages in Iowa, but in the past year Polk County has gained the unenviable reputation of having one divorce for every two marriages. It is recognized

that there has been a marked increase in premarital sexual activity and in promiscuity. More girls are married at the age of 18 than at any other age, and it is reported that a high proportion of them are pregnant at the time of marriage. Venereal disease, particularly among teenagers, is on the increase in the state, as it is throughout the nation.

It is obvious that it is time for parents to be less permissive and, as Dr. Galdston suggests, "to regain their nerve." Youth must be helped to acquire the self-discipline necessary to make a useful and happy life a reasonable expectation. Indoctrination of the eternal virtues within the home when the children are small offers the greatest hope for a good life. Fortunate is the child who finds the support and comfort of a sustaining faith to guide him, and help him cope with the vicissitudes of life and with changing values and mores.

INGESTION OF CAUSTIC SUBSTANCES

The ingestion of caustic substances by accident or with suicidal intent continues to be a problem that is of serious concern to the physician. Both the immediate effects and the late problems following caustic burns of the esophagus can be fatal or can result in complications which challenge the skill and judgment of a medical team. A recent report from the University of Oregon Medical School Hospitals* tells of the management of 60 patients with histories of ingesting caustic substances. It should benefit any physician who is likely to be confronted by patients presenting with this critical problem.

The immediate consequences of caustic ingestion can be severe. Periesophagitis and mediastinitis may occur, and death is not unusual. However the late problems are more common, and it is recognized that they are difficult to manage. The most frequent of the long-term complications of caustic esophagitis is esophageal stricture.

The report relates the experiences of patients seen at the U. of O. Hospitals from 1957 to 1968. All patients presenting with a history of caustic ingestion were hospitalized, whether symptomatic or not. Beginning on the first hospital day, the patients were given 8 mg. of parenteral dexamethasone or 60 mg. of oral prednisone daily, and the dosage was tapered off over a three- to four-day period to a maintenance dose of 5 to 10 mg. of prednisone. Intravenous fluids were administered as indicated, and normal diets were resumed as soon as possible. Antibiotics, usually ampicillin, were also given. Usually within 48 hours after admission, espohagoscopy was performed under general anesthesia. This procedure was done to detect the presence of esophageal burns, and to determine their extent and severity. Patients with no demonstrable burns were discharged without further therapy, and were followed in the outpatient clinic.

Patients in whom burns were observed underwent esophagoscopy at two- to three-week intervals until the burns healed and the mucosa appeared normal, and at this time the steroids were discontinued. Esophagoscopy was repeated one month after cessation of therapy, and at six months a barium esophagram was done. If strictures developed, dilation was carried out, either under direct vision with dilation, or indirectly with bougies. The patients were seen frequently during the first two months, and long-term evaluation was completed at one year.

Of the 60 patients admitted to the hospital, 35 were under three years of age, and all of their ingestions of caustic substances had been accidental. Twenty-five patients were over 30 years of age, and all of them had ingested the caustic substances with suicidal intent. The material usually was an alkali—usually a lye compound. This causes liquefaction necrosis, and tends to invade the deep layers of the mucosa. Acid substances usually cause coagulation necrosis, and the damage usually is limited to the superficial mucosal layers. Of unusual interest was the observation that no diagnostically significant correlation could be found between the presence of oral burns and burns

* Egan, R. S.: Corrosive esophagitis; review of therapy. NORTHWEST MEDICINE, 68:1007-1009, (Nov.) 1969.

Editorials continued...

of the esophagus, and they seemed to have occurred independently of each other.

Esophagoscopy was performed on 55 of the 60 patients. In 21 of the group the findings were normal; 17 had superficial burns of the esophagus; 9 had transmucosal burns; and 2 had full-thickness burns. Six patients were found to have narrowing strictures but they were first seen after the acute stage had passed.

The 28 patients in whom acute esophageal burns were demonstrated were treated by a full course of steroids, usually of three weeks' duration. Antibiotics were also given during the first week of treatment. None of the patients who had a normal esophagus on examination developed strictures. Of the 28 patients in whom burns of the esophagus were demonstrated, two developed strictures. One of them had multiple areas of transmucosal burns which resulted in strictures unresponsive to bougienage, and a colon interposition was successfully performed at a later date. The second patient had severe full-thickness burns of both the esophagus and stomach, with mediastinitis and multiple strictures. This patient died three weeks after the ingestion. Thoracotomy and laparotomy revealed erosion of the distal esophagus and stomach into the great vessels, resulting in uncontrollable hemorrhage. In one patient a perforation occurred from esophagoscopy. Thoracotomy was performed, the mediastinum was drained, and the patient had no further difficulty. The six patients who were admitted with well-formed strictures underwent multiple dilatations with varying degrees of success. Two of these eventually required colon interpositions.

In his discussion the author points out that until the last decade the treatment of corrosive esophagitis was prophylactic bougienage started early, and this method is still advocated at some medical centers. However the results of this method have been disappointing, for reports indicate that strictures have developed in 40 to 80 per cent of patients treated in this manner.

The use of steroids and antibiotics in the treatment of corrosive esophagitis was based upon animal experimentation in which it was shown that they lessened the incidence of stricture if they were administered within the first 48 hours following ingestion of the caustic material. Several clinical trials were carried out, and the incidences of stricture formation were reported to range between 3 and 27 per cent. The incidence of strictures in the Oregon experience was 7 per cent. The greatest improvement has occurred in the superficial and transmucosal burns. Deep burns can still produce strictures, despite the newer treatment. However it is felt that even when strictures do form, bougienage is more effective when steroids have been used in the initial treatment.

The author emphasizes that proper esophageal examination should be carried out in all patients suspected of caustic ingestion. Physicians should not be misled by a period of from one to several weeks of relative freedom from symptoms, following an initial few days of severe difficulty in swallowing. It is only by repeat esophagoscopy that completion of a new epithelial lining can be determined, and it is the completion of the lining that makes subsequent stricture formation unlikely. If steroids are to be successful, they must be administered until their influence on the potential scar tissue is no longer necessary, and that is the time when the open wound has been covered by epithelium.

He concludes that the steroid and antibiotic therapy for corrosive burns of the esophagus resulted in a marked improvement over the 40 to 80 per cent incidence of strictures reported when the older methods were used. The improved results at the University of Oregon compare favorably with those in other reported series of cases treated in a similar manner.

FIRST SESSION
IMS House of Delegates
Sunday, April 26

will be held at the
Fort Des Moines Hotel
rather than at the Savery

WORLDWIDE REGULATIONS REGARDING PREVENTIVE MEDICINE NEED STRENGTHENING

The outbreak of typhoid fever aboard the luxury cruise ship *Oronsay,* in January, was a dramatic example of "turista" at its worst. Travelers in foreign lands frequently have gastrointestinal upsets which are mild and of short duration. In underdeveloped countries where sanitation is most inadequate, enteric infections of a more serious character are a recognized hazard of travel. People who intend visiting such areas are urged to have typhoid vaccination, as well as protective immunizations against other diseases endemic there.

According to press reports, the *Oronsay* took on 40 Goanese crewmen at Southampton before leaving England. The vessel began a four-month world cruise on December 16, 1969, made several stops at Caribbean ports and one in Florida, then proceeded through the Panama Canal, docked successively in Los Angeles and San Francisco, and arrived at Vancouver, British Columbia, on January 14 with 1,045 passengers and 580 crewmen aboard.

The Associated Press reported that five days after the ship's arrival at Vancouver, it was quarantined. Thirty-two crew members and five passengers were in Vancouver hospitals. In addition, six crewmen had been taken ill en route and had been hospitalized in Los Angeles and San Francisco, and two passengers who had disembarked in Florida were reported to have confirmed typhoid fever. Twelve days after the arrival of the ship in Vancouver, it was reported that there were 71 patients in the hospitals there with either confirmed on suspected typhoid fever. The *Oronsay* was still in port, and its departure had been deferred for at least another week while a search for carriers continued.

The *Oronsay* is a British liner of the P & O Line, an old and reliable maritime organization. The ship "fulfills the International Safety Standards for new ships developed in 1948." Despite that "fulfillment of safety standards," it is reported that its water supply was contaminated by enteric organisms. Whether the 40 Goanese crewmen taken on just before the vessel left England had been immunized or carefully screened from a health point of view was not reported in the press dispatches.

Since a considerable share of the patients taken ill and hospitalized were crewmen, it is obvious that if they had ever received prophylactic typhoid inoculations, they had received no booster injections recently to maintain their immunity. It would appear that proof of current immunization against typhoid fever similar to the proof required of recent smallpox vaccination should be demanded of all crewmen. It would also appear that passengers on a cruise of this kind, living in a closed community for weeks and disembarking at numerous ports, should also be required to have had typhoid immunization.


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INFORMATION FROM THE
IOWA HEART ASSOCIATION

Use of Anti-Arrhythmic Agents Other Than Digitalis

LEONARD S. DREIFUS, M.D.
Philadelphia, Pennsylvania

QUINIDINE

The current therapeutic status of quinidine has changed little since Wenckebach's classic observations on recurrent atrial fibrillation. Although many anti-arrhythmic agents have appeared on the pharmacologic horizon, none has surpassed quinidine in efficacy. It is effective in any active arrhythmia, whether atrial, A-V nodal or ventricular. The introduction of precordial electroshock therapy by Zoll and his associates and Lown has imparted a new dimension to the approach to anti-arrhythmic therapy, and has made it possible to convert almost 90 per cent of the patients with atrial fibrillation to sinus rhythm. Nevertheless, the usefulness of quinidine has not diminished, for a pharmacologic program must be instituted to maintain a sinus rhythm even after electroconversion.

The usual drug method of converting atrial fibrillation to sinus rhythm in the digitalized patient consists of administering quinidine in a dosage of 0.2 Gm. every two hours for five doses the first day; 0.3 Gm. every two hours for five doses the second day; 0.4 Gm. every two hours for five doses the third day; and so forth. If conversion fails at 0.6 Gm. (when the total daily dose is 3.0 Gm.), the likelihood of conversion is small, and the maintenance of sinus rhythm is probably not feasible. Higher doses are accompanied by toxicity, quinidine syncope and cardiac standstill. Although quinidine may be useful in converting atrial flutter, the drug should not be used to convert atrial flutter with a 2:1 A-V conduction ratio without prior digitalization, since the vagolytic effects of quinidine may allow 1:1 A-V conduction to occur with a dangerously rapid ventricular rate. Quinidine may be administered in a dose of 0.2 to 0.4 Gm. three or four times a day to control ventricular or atrial premature systoles. Quinidine may be effective in the treatment of arrhythmias associated with Wolff-Parkinson-White syndrome, and occasionally it may abolish the electrocardiographic changes of this syndrome. The combination of a small dose of quinidine, 100 to 200 mg. q.i.d., with propranolol, 10 to 20 mg. q.i.d., has proved extremely effective in controlling Wolff-Parkinson-White tachycardia, recurrent atrial flutter or fibrillation and intermittent ventricular tachycardia.

Traditionally a test of quinidine has been given to elicit idiosyncrasy, but many clinicians utilize the first dose of a therapeutic program for this purpose.

Toxicity may be manifested by pulmonary, gastrointestinal or cardiac signs and symptoms. Cyanosis, respiratory depression, vascular collapse, restlessness, pallor, cold sweat and syncope are not uncommon. Cinchonism may develop with tinnitus, vertigo, visual disturbances, headache, confusion, angioneurotic edema, nausea, vomiting, diarrhea, fever or cutaneous manifestations. Thrombocytopenia has been observed occasionally, and may be associated with a grave prognosis.

A more than 25 per cent widening of the QRS complex is a warning of impending toxicity, and the drug should be discontinued. Cardiotoxicity may be successfully antagonized by 40 to 80 mEq. molar sodium bicarbonate, or 1 to 3 mcg. per minute of isoproterenol.

PROCAINAMIDE

More than 40 years ago it was found that procaine could paralyze extracardiac nerves, but because of rapid hydrolysis, therapeutic levels were difficult to maintain, and procaine never became a clinically useful anti-arrhythmic drug. On the other hand, procainamide, which binds para-aminobenzoic acid and diethylaminoethanol through an NH group, is not affected by the choline esterase of the body, and consequently is effective by the oral and parenteral routes and has a more prolonged action.

The hemodynamic effects of procainamide are not unlike those of quinidine. However, large doses of intravenous procainamide may cause serious hemodynamic derangements.

Although it was originally thought that procainamide depressed the contractility of cardiac muscle less than quinidine, more recent studies suggest that equivalent doses expressed as milligrams per kilogram depress cardiac muscle equally.

Dr. Dreifus is a member of the staff in the Department of Medicine at Hahnemann Medical College.

As with quinidine, it is important to realize that patients having renal damage or congestive heart failure excrete procainamide more slowly than do normal persons, and cumulative effects are a potential danger. Like quinidine, procainamide acts on the atrium and ventricle by increasing the refractory period and conduction time, and has anticholinergic effects on the atria and A-V node. The electrophysiologic effects of the drug are similar to those of quinidine. However these similarities do not adequately explain the successful use of one drug when the other has failed as an antiarrhythmic agent.

Although procainamide is probably less successful than quinidine in reverting atrial fibrillation to sinus rhythm, it has been used in quinidine-sensitive patients. Likewise, it has been effective in restoring sinus rhythm in patients with atrial flutter and atrial tachycardia. Procainamide appears to have a distinct advantage over quinidine in the management of ventricular tachycardia when urgent intravenous therapy is required. The rate of intravenous administration should not exceed 100 mg./min., and electrocardiographic monitoring is imperative during injection. We have frequently and successfully treated atrial tachycardia with block and ventricular tachycardia, with procainamide in the presence of digitalis overdosage. However the management of ventricular or junctional tachycardia in high grade A-V block requires special attention. Depressant agents such as quinidine, procainamide and potassium salts may abolish all subsidiary pacemakers and engender cardiac standstill. Hence, electrical pacing and isoproterenol are best utilized in this clinical situation.

The toxic signs of procainamide include hypersensitivity reactions such as skin eruptions, bone-marrow depression, or lupus erythematosus with proteinuria and polyserositis. The development of hypotension or widening of the QRS complex beyond 25 per cent of control is a definite indication for withdrawal of this agent. As in the use of quinidine, the infusion of hypertonic sodium salts will reverse procainamide toxicity.

LIDOCAINE

The pharmacologic activity and electrophysiologic mechanisms of lidocaine are similar to those of quinidine and procainamide. It has proved extremely effective in terminating ventricular tachycardia, especially in the presence of an acute myocardial infarction and premature ventricular systoles.

The main hallmark of this agent is its superiority to procainamide in certain specific situations when a short-acting agent is required—particularly when the heart has previously been depressed by other anti-arrhythmic agents or when only a transitory anti-arrhythmic effect is indicated. It has been used successfully to control ventricular tachycardia in depressed hearts following open-heart surgery and prior to the termination of extracorporeal circulation. However it is impractical for the very long-term treatment or prevention of paroxysmal ventricular tachycardia. It is safe and effective in a single intravenous dose of 1 mg. per killogram, with repeat doses every 20 minutes to a maximum of 750 mg. Usually an intravenous bolus injection of 50 to 100 mg. is followed by an intravenous drip of 2 to 4 mg./min. to prevent the reappearance of ventricular premature systoles. This agent has significantly reduced the mortality associated with ventricular tachycardia and fibrillation in the presence of an acute myocardial infarction, and has become the most useful anti-arrhythmic agent in the coronary-care unit. Restrictions similar to those given above for quinidine and procaine should be observed in the presence of high grade A-V block.

DIPHENYLHYDANTOIN

Diphenylhydantoin (Dilantin) appears equally effective in both supraventricular and ventricular arrhythmias, and possesses properties which make it effective against digitalis-induced arrhythmias. It has been successful in preventing paroxysmal atrial tachycardia (PAT) when the usually-employed anti-arrhythmic agents have failed. It has proved effective in suppressing atrial, A-V nodal and ventricular premature systoles, and it is particularly effective in terminating digitalis-induced arrhythmias. Its transient action and the rapid reversibility of its toxic effects may give it certain advantages over other depressant agents. However it does not appear effective in converting atrial fibrillation to sinus rhythm. In the treatment of rapid supraventricular or ventricular tachycardias, an intravenous injection of 5 to 10 mg./kg. can be administered slowly, over a 15-minute period, and repeated within two to three hours. The drug can be administered orally, in doses of 100 to 200 mg. four times daily, for the suppression of ectopic beats or for prophylaxis against recurrent paroxysmal tachycardia.

Toxic manifestations of diphenylhydantoin are seen in approximately 10 to 15 per cent of patients, and include nervousness, ataxia, tremors, nystagmus, visual disturbances, respiratory arrest, confusion or drowsiness, gastric distress, erythematous or morbilliform cutaneous eruptions, and hyperplasia of the gums.

BETA ADRENERGIC BLOCKING AGENTS

Interest in blocking the effects of adrenergic nerve stimuli is attributed to Dale, who in 1906 described the reversal of the pressor response to epinephrine by pretreating experimental animals with certain ergot compounds. Ahlquist recognized

(Continued on page 195)

COMING MEETINGS

IN STATE

Apr. 2-3 **Fourteenth Annual Raymond Blank Hospital Pediatric Conference**, Iowa Methodist School of Nursing Auditorium, Des Moines.

Apr. 3-4 **Eighth Annual Orthopaedic and Rehabilitation Seminar**, Younkers Rehabilitation Center, Des Moines.

Apr. 26-29 **Annual Meeting, Iowa Medical Society**, Fort Des Moines Hotel, Des Moines.

CONTINENTAL U. S.

Mar. 1-4 **Midwest Clinical Conference of Chicago Medical Society**, Sherman House, Chicago.

Mar. 2-4 **Clinical Concepts in Infectious Diseases: Manifestations and Management sponsored by American College of Physicians**, University of Florida, Gainesville.

Mar. 2-6 **Tuberculosis Today sponsored by National Communicable Disease Center**, Atlanta, Georgia.

Mar. 5-6 **Postgraduate Course on Advances in Hematology sponsored by University of Nebraska Medical Center**, Campus of Medical Center, Omaha.

Mar. 7-11 **California Medical Association**, Hilton Hotel, San Francisco.

Mar. 8-10 **American Association of Pathologists and Bacteriologists**, Chase-Park Plaza Hotel, St. Louis.

Mar 9-13 **Postgraduate Course on Cardiology and Renal Disease: Patho-Physiology and Pharmacology sponsored by American College of Physicians**, Presbyterian-St. Luke's Hospital, Chicago.

Mar. 9-27 **Postgraduate Course in Occupational and Environmental Medicine sponsored by New York University Postgraduate Medical School**, New York University Medical Center, New York.

Mar. 11-12 **Postgraduate Course on Current Management of Common Orthopaedic Problems**, Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

Mar. 12-14 **Postgraduate Course on Infectious Diseases sponsored by University of Wisconsin**, Madison.

Mar. 16-18 **Postgraduate Course on Pediatrics**, Kansas University Medical Center, Kansas City, Kansas.

Mar. 16-18 **Sectional Meeting of American College of Surgeons**, Sheraton Park Hotel, Washington, D. C.

Mar. 16-20 **Clinical Problems in Internal Medicine sponsored by American College of Physicians**, Cleveland Clinic, Cleveland.

Mar. 18-20 **Annual Scientific Meeting and Third Post-Graduate Course of American Fertility Society**, Washington-Hilton Hotel, Washington, D. C.

Mar. 19-20 **Postgraduate Course on Obstetrics and Gynecology sponsored by University of Nebraska Medical Center**, Campus of Medical Center, Omaha.

Mar. 19-23 **Aspen Diabetes Institute (Seventh Annual) sponsored by Colorado Diabetes Association**, Aspen.

Mar. 19-24 **American Dermatological Association**, Boca Raton Hotel, Boca Raton, Florida.

Mar. 20-21 **Fourth National Congress on Socio-Economics of Health Care**, Palmer House, Chicago.

Mar. 20-22 **Arizona Chest Disease Symposium (Sixth Annual)**, Ramada Inn, Tucson.

Mar. 23-25 **Postgraduate Course on Surgery**, Kansas University Medical Center, Kansas City, Kansas.

Mar. 23-26 **Neurology and the Internist sponsored by American College of Physicians**, Mayo Clinic and Mayo Graduate School of Medicine (University of Minnesota), Rochester.

Mar. 25-26 **Postgraduate Course on Medical Progress and Its Relationship to Dentistry**, Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

Mar. 25-26 **Symposium for Physicians Practicing General Medicine, 7th Spring Annual, sponsored by Los Angeles County Heart Association and Los Angeles Academy of General Practice**, Los Angeles.

Mar. 25-28 **Neurosurgical Society of America**, Ojai Valley Hotel, Ojai Valley, California.

Mar. 30-31 **Postgraduate Course on Psychiatry in General Practice sponsored by University of Nebraska Medical Center**, Campus of Medical Center, Omaha.

Mar. 30-Apr. 3 **Postgraduate Course on Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment sponsored by American College of Physicians**, University of Michigan Medical Center, Ann Arbor.

Mar. 30-Apr. 4 **American College of Radiology**, Statler-Hilton Hotel, Dallas.

Apr. 1. **First Alcoholism Medical Education Conference, sponsored by National Council on Alcoholism**, 2 Park Avenue, New York City.

Apr. 1-2 **Postgraduate Course on Advances in Infectious Disease**, Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

Apr. 2-3 **Practicing Physician and Endocrine Metabolic Disorders in Children sponsored by University of Nebraska Medical Center**, Campus of Medical Center, Omaha.

Apr. 2-5 **Missouri State Medical Association**, Muehlebach Hotel, Kansas City.

Apr. 3-4 **American Geriatrics Society**, Americana Hotel, New York.

Apr. 6-7 **Postgraduate Course on Sports Medicine**, Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

Apr. 6-8 **American Association for Thoracic Surgery**, Washington-Hilton Hotel, Washington, D. C.

Apr. 6-8 **Postgraduate Course in Ophthalmology**, Kansas University Medical Center, Kansas City, Kansas.

Apr. 6-10 **Tuberculosis Today sponsored by National Communicable Disease Center**, Atlanta, Georgia.

Apr. 6-10 **Postgraduate Course on High Risk Infant Care (Limited) sponsored by University of Colorado School of Medicine**, Denver.

Apr. 6-17 **Postgraduate Course in Laryngology and Bronchoesophagology sponsored by University of Illinois Medical Center**, Chicago.

Apr. 9-10 **Dreams and Reality in Maternal Child Nursing**, U. of Kansas Medical Center, Kansas City.

Apr. 9-10 **23rd National Conference on Rural Health**, Pfister Hotel and Tower, Milwaukee.

Apr. 9-11 **Tennessee Medical Association**, Sheraton-Peabody Hotel, Memphis.

Apr. 9-11 **Current Concepts in Physiology of the Gastrointestinal, Endocrine and Respiratory Systems sponsored by American College of Physicians and American Physiological Society**, Holiday Inn, Philadelphia.

Apr. 10	**Postgraduate Course on Pediatric Neurology sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.
Apr. 10-12	**American Society of Internal Medicine,** Warwick Hotel, Philadelphia.
Apr. 12-16	**American Proctologic Society,** The Diplomat, Hollywood, Florida.
Apr. 12-17	**American College of Physicians,** Bellevue Stratford Hotel, Philadelphia.
Apr. 12-17	**American Physiological Society,** Holiday Inn, Atlantic City.
Apr. 12-18	**American College of Obstetricians and Gynecologists,** Americana Hotel, New York.
Apr. 13-15	**American Academy of Pediatrics,** Washington-Hilton, Washington, D. C.
Apr. 13-15	**Postgraduate Course in Anesthesiology,** Kansas University Medical Center, Kansas City, Kansas.
Apr. 13-16	**American Industrial Health Conference sponsored by Industrial Medical Association and American Association of Industrial Nurses,** Palmer House, Chicago.
Apr. 13-17	**American Association of Immunologists,** Atlantic City.
Apr. 15-17	**Postgraduate Course on Management and Care of Respiratory Insufficiency sponsored by University of Colorado School of Medicine,** Denver.
Apr. 16-18	**Indiana Chapter, American College of Surgeons,** Indiana State University, Terre Haute.
Apr. 16-18	**The Pulse of Laboratory Medicine sponsored by University of Florida College of Medicine, Pinellas County Medical Society and Florida Academy of General Practice,** Tides Hotel and Bath Club, Redington Beach, Florida.
Apr. 17	**Postgraduate Course on Infectious Diseases,** Kansas University Medical Center, Kansas City, Kansas.
Apr. 19-20	**American Otological Society,** Hollywood Beach Hotel, Hollywood, Florida.
Apr. 19-23	**American Association of Neurological Surgeons,** Shoreham Hotel, Washington, D. C.
Apr. 20-23	**Southwestern Surgical Congress,** Sheraton-Dallas Hotel, Dallas.
Apr. 21-25	**Arizona Medical Association,** Marriott's Camelback Inn, Scottsdale.
Apr. 22-23	**Postgraduate Course in Pathology,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.
Apr. 22-24	**Second Annual Symposium on Chronic Respiratory Diseases sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.
Apr. 23-25	**Annual Meeting Mid-Central State Orthopaedic Society,** Skirvin Hotel, Oklahoma City.
Apr. 23-25	**Postgraduate Course on Recent Advances in Endocrinology and Selected Metabolic Diseases sponsored by American College of Physicians,** University of California Medical Center, San Francisco.
Apr. 26-29	**Arkansas Medical Society,** Arlington Hotel, Hot Springs.
Apr. 27-29	**American Surgical Association,** The Greenbrier, White Sulphur Springs, West Virginia.
Apr. 27-30	**Nebraska State Medical Association,** Hotel Cornhusker, Lincoln.
Apr. 27-May 2	**American Academy of Neurology,** Americana Hotel, Miami Beach.
Apr. 29-May 2	**American Pediatric Society,** Traymore Hotel, Atlantic City.
Apr. 30-May 3	**Texas Medical Association,** Dallas.

ABROAD

Mar. 8-14	**International Congress of Ophthalmology (21st),** Mexico City.
Mar. 13-20	**Paediatric Surgical Meeting,** Melbourne.
Mar. 17-20	**Canadian Association of Radiologists, 33rd Annual Meeting,** Montreal.
Mar. 19-21	**Association of Clinical Pathologists,** Edinburgh.
Mar. 30-Apr. 4	**Latin-American Congress of Obstetrics and Gynecology (6th),** San Jose, Costa Rica.
Apr. 1-4	**German Surgical Society,** Munich.
Apr. 6-8	**European Congress of Perinatal Medicine,** London.
Apr. 9-11	**Biennial Meeting on Gynecology and Obstetrics,** Mexico City.
Apr. 11-17	**American Orthopaedic Association, Annual Meeting,** Melbourne, Australia.
Apr. 20-24	**17th Biennial Congress, International College of Surgeons,** Paris.
Apr. 26-30	**First International Congress on Group Medicine,** Winnipeg, Manitoba, Canada.
Apr. 30-May 1	**Irish Ophthalmological Society,** Dublin.

Information from Iowa Heart Association

(Continued from page 192)

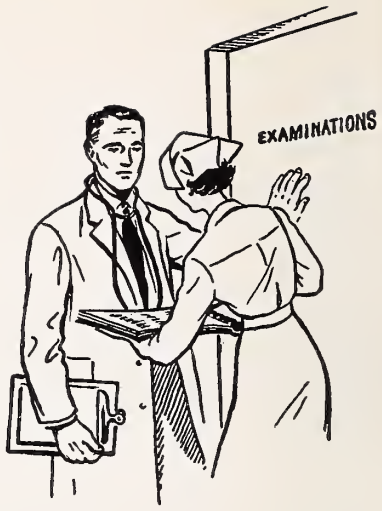
two types of adrenergic receptors, and designated them "alpha" and "beta."

Propranolol reduces the heart rate and cardiac contractile force. Arterial pressure and ascending aortic flow are slightly reduced in anesthetized dogs. Since these changes do not occur after depletion of norepinephrine stores by syrosingopine, it has been concluded that they result from blockade of restive sympathetic drive. In human patients, administration of propranolol will cause a decrease in cardiac output, and in left ventricular work at rest and during exercise. Propranolol will abolish the vasodilation effects of epinephrine and isoproterenol, but not the vasoconstrictor effects of the catecholamines, on the peripheral vessels.

With intravenous administration, propranolol exerts a rapid anti-arrhythmic action. Propranolol is usually given slowly in doses of 1 to 5 mg. intravenously (no more than 1 mg. every two to three minutes), or 15 to 30 mg. three to four times daily may be given orally to prevent a return of ectopic beating. The action is usually immediate during the intravenous administration, and the drug may be repeated within two to three hours.

The side effects of propranolol may include lightheadedness, drowsiness, nausea, diarrhea, sleeplessness, rashes, visual disturbances, purpura, paresthesias, flushing and mental confusion. The pharmacologic effects of propranolol have produced hypotention, bradycardia, cardiac failure, A-V heart block, bronchial wheezing and aggravation of mild obstructive pulmonary disease.

THE DOCTOR'S BUSINESS



The Use of Statistics

LARRY E. LEAVERTON
Des Moines

Statistics on the incidences of various diseases and on the effectiveness of certain drugs in the treatment of patients or in medical research are not strange to the practicing physician. Some doctors follow the Dow Jones Averages, the Standard & Poor's Index and the rise in the Gross National Product. Recently prominent have been figures from the Bureau of Labor Statistics including often-quoted measurements of the cost of health care as compared with the general cost-of-living index.

Statistics play a very important part in our business and economy today. Some authorities define statistics as "the language of business." You have to know what *has* happened if you are to estimate what *may* happen, and reach good, sound business decisions.

What are the purposes of collecting these statistical data? There are several: to keep management informed; to keep track of trends; and to make forecasts of the future, i.e., based upon past results, such and such can be expected to happen.

One way in which to tell how well you are managing your practice is to compare it with the practices of your colleagues in similar circumstances.

How can you use this information? There are many questions it can help you to answer:

What do you want to accomplish this year? For example, our projected rate of inflation is 5 per cent. Thus your net income must increase by 5 per cent if you are to stay even with the economy.

Is your overhead too high?

How about your collection ratio? Based on an "age analysis," do you know what your accounts receivable are worth?

What is your time worth per hour? How is your time being utilized? It is not the hours you put in, but what you put into the hours.

Are you saving enough for your retirement? How do your savings and investments compare with those of other doctors in your income range? If you are 45 years of age, your life expectancy is 74 years, and if you want to retire at 65 you have 20 years left in which to work, and must provide for nine years of retirement. If your age is 50, your life expectancy is 75 years. You have 15 years left to work, and 10 years of retirement to prepare for. It is important to start immediately. For example, a doctor 35 years of age needs to save $174 if, compounded annually at an average rate of 6 per cent, he is to have $1,000 at age 65. Beginning at 50 years of age, he needs to save $417.

For the doctor with an overspending problem, there are figures to show what the average physician spends for personal living expenses and life insurance premiums, and what he saves and invests.

What goals should you set for yourself? The successful physician is well organized and has long-range objectives. He has in mind the ways and means to achieve those objectives, and a timetable for reaching them.

In addition to consulting firms, some sources of statistics dealing with medical practice are the AMA Department of Survey Research, the American Academy of General Practice and other specialty associations, the medical business journals such as MEDICAL ECONOMICS and PHYSICIAN'S MANAGEMENT, and the U. S. Government's Bureau of Labor Statistics and Consumer Price Index figures.

Statistics for your own practice can be accumulated from your appointment book and daybook. How does your time break down between office and hospital? What is your average patient load? How many hours do you put in per week? Are they increasing? Can they be made more productive?

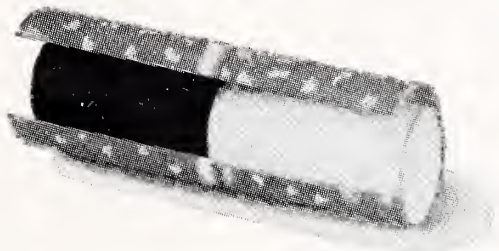
To manage his practice and his personal affairs efficiently, a physician should know how he compares with his colleagues who have similar practices and situations. If he is below average, he should find out why. Are his costs for rent, sal-

(Continued on page 207)

Mr. Leaverton has been associated with Professional Management Midwest since 1949. He is a partner in the firm, and is director of its Research and Development Department.

How do you make a better cigarette?

Here's how:



Tareyton's activated charcoal
scrubs the smoke to smooth the taste
the way no ordinary filter can.

Put Tareyton's activated charcoal filter on your cigarette, and you'll have a better cigarette. But not as good as a Tareyton.



Iowa Association of Medical Assistants

Our Aching Feet!!!!

After listening to the reports of some of those 75 medical assistants who were guests of the Abbott Laboratories, in Chicago, January 15, 16, 17, I felt a few comments on "Our Aching Feet" would be quite appropriate. On such a sightseeing tour and also on shopping expeditions we have the fun, but the real "wear and tear" of any trip is sustained by those often neglected extensions of our legs.

Most of us spend a great deal of our time on our feet and correct shoes, posture, and care usually make a world of difference in how we feel. When our feet hurt, we tire much more quickly; and besides fatigue we suffer from backache, leg cramps, headache, and nervousness. Moreover, the fact that we are busy helping patients does not make us immune to these quite common complaints.

The human foot is quite a marvel of biological engineering, consisting of 26 bones bound together with ligaments, propelled by muscles, and equipped with nerves and blood vessels, and it is subject to more pressure than any other part of the body. The average housewife walks about 10 miles per day. How many miles do we, as medical assistants, walk in a day? The distance varies, of course, depending on the types of work we do in our respective offices.

If your "dogs are barking" at the end of a day, here are a few suggestions. Soak your feet in warm, sudsy water. Dry the feet carefully, blotting rather than rubbing and be sure to dry between the toes. Sprinkle on some powder, and see how good your poor extremities feel.

Cut the nails straight across to help prevent ingrown nails, and smooth the edges with an emery board. Toenails deserve the same fine care we give our fingernails. If you have corns, don't try trimming them with a knife or razor blade! A corn is a warning sign that an area is being irritated; so check to see that your shoes fit correctly.

Rest and exercise are beneficial. Elevate your feet for a little while, if possible, when you are lying down. Try to include foot exercises every night. Walk barefoot on your toes around the room. Then sit down, stretch out your legs and move your feet backwards and forwards as far as they will go for several minutes. Picking up small objects, like marbles or pencils, with the bare toes is also a good exercise. In a recent Gallup poll, people were asked what they complained about most, and four out of five answered, "My feet."

In spite of this sad commentary, our Iowa Medical Assistants had a wonderful time touring the Abbott facilities, seeing the actual production of the drugs right down to the packaging, and the tremendous amount of time and work spent on research to prepare these drugs for marketing. Once again, the benefits of belonging to a professional organization and in taking part in its educational projects became apparent.

Have you marked your calendars—for the State Convention, May 15, 16, 17, in Waterloo; and National AAMA, in Des Moines, October 25 through 31? Watch this page for complete details as the time draws near for each of these big events!

—Jeanne D. Green

"In order to be able to go to bed at night with satisfaction, get up in the morning with determination."—*Scott County Credit Bureau*

Congratulations to new chapter presidents:

Cedar Rapids:
Mrs. Dottie Richardson
847 South Main
Monticello, Iowa 52310
Employed by Drs. R. W. Myers and L. D. Caraway

Davenport:
Mrs. Nancy Winter
230 Kirkwood Blvd.
Davenport, Iowa
Employed by Drs. C. M. Zukerman and B. R. Goldman

Des Moines:
Mrs. Charlotte Fell
1808 Elm
West Des Moines, Iowa 50265
Employed by Dr. Louis Fingerman

Mason City:
Mrs. Frances Cates
1029-12th Place N.E.
Mason City, Iowa 50401
Employed by Drs. P. W. Morgan, J. R. Utne, and B. J. Broghammer

(Continued on page 207)

PROGRAM
WOMAN'S AUXILIARY
to the
IOWA MEDICAL SOCIETY
1970 Annual Meeting—Hotel Kirkwood, Des Moines

Program Theme: "Support Organized Medicine Through Emphasis on Children and Youth"

MRS. DANIEL W. COUGHLAN, *Presiding*

ALL PHYSICIANS' WIVES INVITED

SUNDAY, APRIL 26, 1970

1:00 p.m. REGISTRATION FOR BOARD OF DIRECTORS—Lobby, Hotel Kirkwood

1:30 p.m. MEETING OF BOARD OF DIRECTORS—Iowa Room

6:30 p.m. SOCIAL HOUR AND BUFFET DINNER (Dutch) for board members, convention chairmen, husbands and special guests at the home of Dr. and Mrs. Joseph F. Veverka, Prairie City

MONDAY, APRIL 27, 1970

8:00 a.m.-3:00 p.m. REGISTRATION—Lobby
Luncheon tickets available until 11:30 a.m.

8:00 a.m. THIRD ANNUAL PAST PRESIDENTS' BREAKFAST (Dutch)—Veranda Room

8:00 a.m.-8:45 a.m. COFFEE AND ROLLS—West Room

9:00 a.m. FORMAL OPENING OF THE FORTY-FIRST ANNUAL MEETING—Capitol and Marquette Rooms
House of Delegates in session

12:30 p.m. LUNCHEON—Pioneer Room—Honoring County Presidents and Past State Presidents

Speaker—Dr. Paul F. Sharp, President Drake University

Presentation of Volunteer Health Service Award
Address—WA-SAMA Representative

7:00 p.m. DUTCH TREAT DINNER FOR STATE OFFICERS, Board Members and Guests (National President, Out-of-State Presidents and Presidents-Elect) Des Moines Club

TUESDAY, APRIL 28, 1970

8:00 a.m.-12:00 noon—REGISTRATION—Lobby.
Luncheon tickets available until 11:30 a.m.

8:00 a.m.-8:45 a.m.—COFFEE AND ROLLS—West Room

8:00 a.m.—AREA PLANNING SESSION—Capitol Room. All Central Area physicians' wives are to attend—Mrs. Ralph Hines presiding. (This meeting contingent on continuation of present bylaw provision.)

9:00 a.m. CALL TO ORDER—SECOND SESSION OF THE FORTY-FIRST ANNUAL MEETING—Capitol and Marquette Rooms

House of Delegates in session

Memorial Service—Mrs. Max E. Olsen

Presentation of AMA-ERF Awards

12:30 p.m. LUNCHEON—Pioneer Room—Honoring National President, Retiring State President and Auxiliary Guests

Invitation extended to the Honorable Robert D. Ray, Governor of the State of Iowa to be Guest Speaker

Special Luncheon Guests—William F. Krigsten, M.D., and J. H. Sunderbruch, M.D., president and president-elect of the Iowa Medical Society

Speaker—Mrs. John M. Chenault, National Auxiliary President

Installation of Officers—Mrs. John M. Chenault, National Auxiliary President, presiding

Inaugural Address—Mrs. L. H. Prewitt

Presentation of past-president's pin—Mrs. James Bishop

Adjournment

Post Convention Board Meeting—Iowa Room—Mrs. L. H. Prewitt presiding

6:00 p.m. IOWA MEDICAL SOCIETY PRESIDENT'S RECEPTION AND BANQUET—Hotel Fort Des Moines

From the President's Desk

It is our considered opinion that the upcoming Annual Meeting of the Woman's Auxiliary to the Iowa Medical Society, to be held April 26-27, 1970, at the Kirkwood Hotel in Des Moines, will hold much of interest for all of our members.

Several interesting talks have been planned, and an effort has been made to allow Auxiliary members and guests more time for meeting and visiting with old and new friends.

We have made a bid for very important and distinguished speakers, and we are looking forward to the presentation of much interesting and informative material.

At the start of each morning session you will have a chance to have coffee and rolls with your friends prior to the opening of the business sessions.

All members are especially invited to attend the luncheons on Monday, April 27, and Tuesday, April 28. The decorations promise to be unique, the company delightful and the food delicious.

Iowa is particularly honored this year in having as a national representative, Mrs. John M. Chenault, president of the Woman's Auxiliary to the American Medical Association. Mrs. Chenault is an interesting and witty speaker, and her warm Southern personality is particularly engaging.

After perusing the program which precedes these remarks, we hope all of you are stimulated to attend the Annual Meeting. We are looking forward to seeing you there.

—JEANNE COUGHLAN (MRS. D. W.)

Legislation Breakfast

On Tuesday, February 10, the Iowa Medical Society building was the scene of a continental breakfast, sponsored jointly by the Woman's Auxiliaries to the Iowa and Polk County Medical Societies, for the wives of the state legislators. The president-elect of the Iowa Medical Society, Dr. J. H. Sunderbruch, of Davenport, showed slides and talked on "Medicine Behind the Iron Curtain." Dr. Sunderbruch spent three weeks behind the Iron Curtain on a People-to-People tour last fall. Many questions followed his presentation.

Special guest, Mrs. Robert Ray, wife of Iowa's governor, was introduced by Mrs. Daniel Coughlan, president of the Woman's Auxiliary to the Iowa Medical Society. Mrs. Roger Jepson, wife of Iowa's lieutenant governor, was introduced by Mrs. L. H. Prewitt, Auxiliary president-elect. Mrs. F. M. Burgeson, Polk County Auxiliary president, introduced Mrs. Ray C. Cunningham of Ames, president of the Legislative Ladies League. Mrs. C. A. Trueblood, Polk County Legislation Chairman, thanked those who helped with arrangements. Special hostesses were: Mrs. F. M. Burgeson, Mrs. Joseph Song, Mrs. R. J. Foley, Mrs. M. R. Saunders and Mrs. E. M. Smith.

In charge of registration was Mrs. C. J. Peisen assisted by Mrs. Robert Reed.

Table arrangements were made by Mrs. Robert Cornish, assisted by Mrs. Richard Preston and Mrs. Robert Jones.

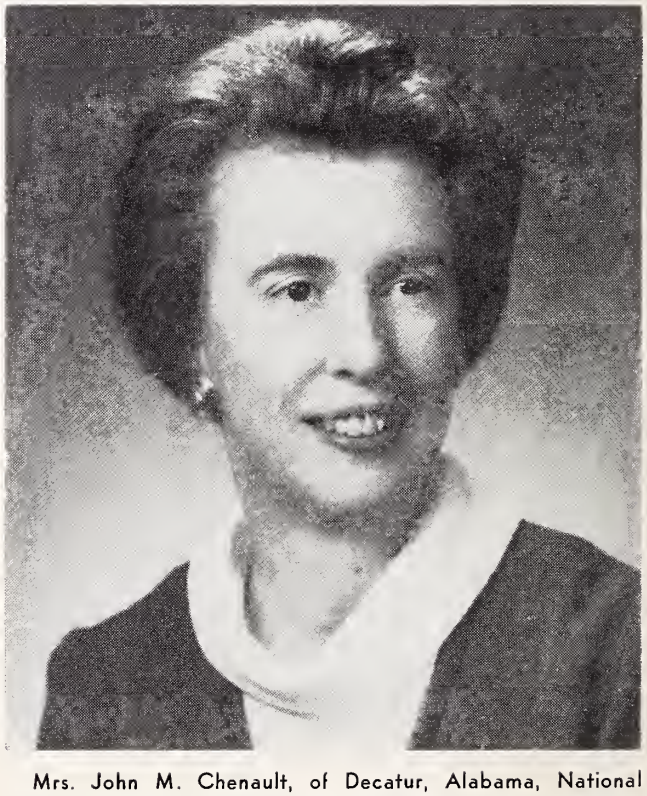
Pouring were: President-Elect, Mrs. L. H. Prewitt; Mrs. Dwight Wirtz; Mrs. R. L. Wicks, second vice-president; and a past-president, Mrs. R. E. Hines.

Transportation was arranged by Mrs. Lawrence Ely.

The members-at-large from Kossuth County addressed and mailed the invitations.

The (now-annual) event was attended by approximately 175 Legislative Ladies, Auxiliary members and friends. Following the morning's activities, a visit to the State Capitol was arranged, so the women could observe the Legislature in session. This was planned to promote further understanding of the legislative process, as well as to give women of both groups a continued opportunity to develop friendship and understanding. Aiding in plans to visit the Legislature were Mr. Eldon Huston, Mr. Kent Jerome and Mr. Virgil Deering, legislative contact men for the Iowa Medical Society. Their background information did much to make the visit both interesting and worthwhile.

BETTY SCHUTTER (MRS. JOHN M.)
Legislation Chairman



Mrs. John M. Chenault, of Decatur, Alabama, National President of the Woman's Auxiliary to the American Medical Association, will be the Iowa Auxiliary's guest at its annual convention next month. Mrs. Chenault will preside at the installation of officers and will address the group at the Tuesday session.

Around the Hawkeye State

Black Hawk County

Mrs. Orrin Hall, president of the Woman's Auxiliary to the Black Hawk County Medical Society, has pronounced the 11th Annual Medical Ball, held February 7, a great success.

The theme chosen for this year's ball was "Hearts and Flowers" with elaborate decorations to carry out the theme. The event was held at the Electric Park Ballroom, in Waterloo, and there was dancing to the music of the Bruce Young orchestra. Tickets sold for $15.00 per couple, with proceeds to be used to aid medical charities.

Mrs. Robert Swaney, Mrs. Edward Ceilly and Mrs. David Aldrich were in charge of the ticket sales; Mrs. Bard Stevenson, publicity; Mrs. Richard Long, social hour; and Mrs. Thomas Spragg, general chairman of the affair.

Buchanan County

Members of the Buchanan County Woman's Auxiliary met at Hotel Pinicon, at Independence, on January 14. Donations were sent to the Girl Scout headquarters to be used for the campership of a Buchanan County girl, and to AMA-ERF to be used in the medical field, either for research or for the medical-student loan program.

The third annual ball sponsored by the local Auxiliary is to be held April 25, at the Gayla. Mrs. Richard Myers and Mrs. John Mochal were named co-chairmen.

Dr. Chester McClure presented a film on drugs, and his talk was followed by a question-and-answer period. The movie was attended by the superintendent and several faculty members of the Independence schools, and by school board members in addition to the Auxiliary members.

Dallas-Guthrie

Dr. and Mrs. K. M. Chapler were hosts to the Dallas-Guthrie Medical Society and Auxiliary at the Library Hall, in Dexter, on January 15. A social hour preceded the dinner. Favors at each place consisted of a box of Drew's chocolates, presented by the hosts, and packages containing an address book, a date book and a ball point pen courtesy of the Isenberg Pharmacy.

Special guests included Mrs. D. W. Coughlan, of Des Moines, president of the Auxiliary to the Iowa Medical Society; Mrs. Hazel T. Lammey, of Des Moines, administrative secretary of the Woman's Auxiliary to the Iowa Medical Society; Dr. and Mrs. Alfred N. Smith, of Des Moines, and Mrs. Julie Seidler, of Dallas, Texas.

Following dinner, Dr. C. A. Nicoll, of Panora, president of the Dallas-Guthrie Medical Society, presided over the medical meeting. Dr. Smith, the guest speaker, discussed "Peripheral Vascular Disease of the Lower Extremities." A business meeting followed his talk.

Mrs. K. M. Chapler, president of the Auxiliary, conducted the Auxiliary's business meeting, after which Mrs. D. W. Coughlan gave a general resumé of Auxiliary activities, objectives and goals. Afterward, there was a question-and-answer period, in which Mrs. Lammey participated.

Polk County

Many of our Auxiliary members served as lay or nurse volunteers for the Polk County rubella immunization clinics held from January 26 through February 3.

Mrs. Harold Eklund, International Health chairman, opened her home to members of the Auxiliary on February 16 and 20, from 10:00 a.m. until 3:00 p.m., so that they might sew Johnny Coats, draw sheets and crib sheets, etc. Luncheon was served to the workers.

Since last May, memorial contributions have been made to AMA-ERF on behalf of the families of Mrs. Lawrence Porter, Dr. Frank Fordyce, Dr. Howard Turner, Dr. Verle Ruth, Dr. James Cromwell, Dr. Helen Johnson and Mrs. Floyd Springer, and cards of sympathy have been sent to their families.

The Woman's Auxiliary to the Iowa and Polk County Medical Societies entertained the wives of the Iowa General Assembly members at a continental breakfast on February 10, at the Iowa Medical Society Building. Following the breakfast, Dr. John H. Sunderbruch presented an informative program "Medicine Behind the Iron Curtain." Many Polk County Auxiliary members assisted with the planning and hostessing at this function.

Historian's Request

If you have any pictures of your Auxiliary in action, please send them to me with details. Any newsclipping of your projects and special activities with historical value should be made available for our history. Please send to: Mrs. Harry W. Dahl, 2935 John Patterson Road, Des Moines 50317.

Have you moved in the past few months? PLEASE send any changes of address to 1001 Grand Avenue, West Des Moines, Iowa 50265. Communication is a necessity: Do help keep our mailing list up to date. You are our best source of accurate information.

Children and Youth: Drugs! Abortion! Suicide!

Urgent action must be taken to spare our youth from ruining their lives. So urgent is the need that the National Auxiliary has created a new committee—CHILDREN and YOUTH. The problem is multiphased; it is demanding; it is vital.

Emphasis will be varied: drug abuse, alcohol, violence in TV and movies, sex education, venereal disease, teenage pregnancy, abortion, suicide, child abuse, immunizations, smoking. We must open our eyes to these urgent health problems, and then open the eyes and minds of our communities.

Our attack must be swift and sure. Our attack must be made on a professional level, yet we must allow our youth to relate to and identify with the problem.

Please contact me if you have any questions, or need advice or assistance on any of the above problems. Be sure to have the approval of your medical society before you start any of these programs.

I shall be looking forward to your requests for materials and suggestions. Good Luck with your effort. Together we may be able to spare someone some unhappy experiences.

All of us are sorry that there are some children-and-youth problems, but fortunately there are also a great majority of youngsters in this age group who are not involved and can provide excellent help for you in your program.

MARY ELLEN KIMBALL (MRS. J. D.)
1015 Lake Shore Drive
Osceola, Iowa 50213

AMA-ERF Fund Raising Projects

Note Paper

Playing Cards

Mrs. R. M. Perkins
125 East Rusholme Street
Davenport 52803

or

Woman's Auxiliary Office
1001 Grand Avenue
West Des Moines 50265

Membership Deadline

The deadline of March 31 for the treasurer's report to National is fast approaching. This is the deadline which determines the number of delegates Iowa will be entitled to at the National Convention in Chicago. If you have not paid your current Auxiliary dues, please make every effort to take care of that little item NOW!

If you are a member of an organized county Auxiliary, send your dues to your county treasurer. Members-at-large, mail your dues to the Councilor of your district from whom you have heard or mail diectly to the state treasurer, Mrs. J. F. Veverka, Box 324, Prairie City, 50228, and she will notify your councilor and see that your membership card reaches you prior to the Annual Meeting.

President-Elect's Message

"Road Signs on a Merry-Go-Round" are showing us the way to the Annual Meeting April 26-28. We are heading into the home stretch of this Auxiliary year. The winter Board meeting was a most enjoyable occasion, so I've been told; it was the only one I've had to miss in five years! At the meeting on the preceding day, Jeanne told us how plans were shaping up. You will enjoy the speakers, and it's worth a trip to Des Moines to meet and know the national representative who will be with us.

One of the nicest features is that you will have some time to visit with old and new friends. I think all of us are aware of the special effort Jeanne has made this year to give us time to know one another, and that has been great. You can't beat having fun while you're working! And that's the kind of team it has been.

The master mind for Annual Meeting, in charge of the machinery that makes the wheels go round is Gene Dorner. She has all the right gremlins working for her. Kathy Weiss and her gals from Davenport are whipping up delightful decorations for the luncheon tables. Watch for details, and send in your reservations early. This is the springboard for our new decade—the Explosive Seventies!

MARION PREWITT (MRS. L. H.)
President-elect

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. D. W. Coughlan, 1435 Park Avenue, Des Moines 50315
President-Elect—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501
Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312
Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228
Editor of THE NEWS—Mrs. D. A. Mater, 302 S. 4th Street, Knoxville 50138
Assistant Editor—Mrs. R. J. Foley, 1025-16th Street, West Des Moines 50265



POLK COUNTY MEDICAL SOCIETY

ORIENT ADVENTURE

Two fun-filled weeks in exotic and colorful Japan and Hong Kong. Our complete Orient Adventure costs much less than round trip tourist air fare, yet includes direct 707 private jet flights, deluxe hotels, gourmet meals, all the freedom of individual travel, plus many other exclusive features. The Orient Adventure is departing

DES MOINES, IOWA

May 2, 1970

Polk County Medical Society
606 Equitable Building
Des Moines, Iowa 50309

Enclosed is my check for $ _____
($100 per person) as deposit.

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Address _____

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☐ Please send me full color brochure.

$899.00

STATE DEPARTMENT OF HEALTH

Rubella Vaccine

Recommendations and Cautions

RONALD D. ECKOFF, M.D., M.P.H.

The following summary of recommendations and cautions regarding the use of rubella vaccine is taken from the more complete statement printed in the August, 1969, issue of this JOURNAL. The package inserts which accompany the vaccines should also be consulted regarding use and cautions.

Live rubella-virus vaccine is recommended for boys and girls between one year of age and puberty. The vaccine should not be administered to infants less than one year old because of a possible interference from persisting maternal rubella antibody. A history of rubella illness is usually not reliable enough to constitute a basis for excluding children from immunization.

Pregnant women should not be given rubella-virus vaccine. It is not known to what extent the fetus might be infected by attenuated virus following vaccination, or whether damage to the fetus could result. Therefore *routine* immunization of adolescent girls and adult women *should not* be undertaken because of the danger of inadvertently administering vaccine to a pregnant female before her pregnancy becomes evident.

Women of child-bearing age may be considered for vaccination only when the possibility of pregnancy during the following two months is essentially nil; each case must be considered individually. This cautious approach to the vaccination of post-pubertal females is indicated for two reasons: first, that there is a theoretical risk of vaccinating during pregnancy; and second, that congenital anomalies occur regularly in approximately 3 per cent of all births, and their fortuitous appearance after vaccination during pregnancy could lead to a serious misinterpretation.

If the vaccination of a woman of child-bearing age is contemplated, the following steps are indicated:

Optimally, the woman should be tested for susceptibility to rubella by the HI test (available at the State Hygienic Laboratory).

If immune, she should be assured that vaccination is unnecessary.

If susceptible, she may be vaccinated only if she understands that it is imperative for her to avoid becoming pregnant for the following two months. (To insure this, a medically acceptable method for pregnancy prevention should be followed. This precaution also applies to a woman who is vaccinated in the immediate postpartum period.) Additionally, she should be informed of the frequent occurrence of self-limited arthralgia, and of the possible occurrence of arthritis beginning between two and four weeks after vaccination.

Use of vaccine after exposure to natural infection. There is no evidence that the administration of live rubella-virus vaccine after exposure will prevent illness. There is, however, no contraindication to vaccinating children who already have been exposed to natural rubella. For women exposed to rubella, the concepts listed previously apply.

PRECAUTIONS FOR THE USE OF LIVE RUBELLA-VIRUS VACCINE

Pregnancy: Live rubella-virus is contraindicated.

Altered immune state: Attenuated rubella-virus infection may be potentiated by severe underlying diseases such as leukemia, lymphoma or generalized malignancy, and when resistance has been lowered by therapy with steroids, alkylating drugs, antimetabolites or radiation. Vaccination of such patients should be avoided.

Severe febrile illness: Vaccination should be postponed until the patient has recovered.

Hypersensitivity to vaccine components: Rubella vaccine is produced in cell culture. Care should be exercised in administering vaccine to persons with a known hypersensitivity to the species from which the cells were derived. (The source will be indicated by the labeling.) The vaccine contains a small amount of neomycin and should not be given to individuals known to be sensitive to this antibiotic.

SIMULTANEOUS ADMINISTRATION OF LIVE RUBELLA-VIRUS VACCINE AND OTHER LIVE-VIRUS VACCINES

Simultaneous administration of live rubella-virus vaccine and other live-virus vaccines should be deferred until results of controlled clinical investigations become available. Until then, it is recommended that rubella vaccination be separated by at least one month from administration of other live-virus vaccines.

Aerobic Exercise as a Preventive for Coronary Heart Disease

The American Heart Association lists several risk factors for heart disease: high cholesterol, overweight, high blood pressure, cigarette smoking, diabetes, lack of exercise and a family history of heart disease.

The Iowa State Department of Health is active in programs designed to discourage cigarette smoking, to encourage sound nutritional practices, and to inform people about diabetes. The Department will now expand its activities in the fight against coronary heart disease by implementing an exercise program that has been tested and proved of use as a preventive.

Based on the evidence which Major (now Lieutenant Colonel) Kenneth Cooper accumulated in his studies on Air Force personnel and published in "Aerobics," this program stresses conditioning to produce endurance fitness. Fitness is defined as the difference between the minimum physical requirements for daily activities and a maximum capacity to perform. Major Cooper documented the "training effect," which

1. Increases the efficiency of the lungs so that more air can be processed with less effort
2. Increases the efficiency and strength of the heart, thus decreasing the heart rate
3. Improves the tone of the muscles and blood vessels and strengthens them, often reducing blood pressure
4. Changes fat weight to lean weight, but not necessarily reduces total weight
5. Increases maximum oxygen consumption by increasing the efficiency of its transport and delivery
6. Usually changes mental attitude, improves outlook and decreases fatigue.

The air around us contains 21 per cent oxygen. In the deconditioned lung, about 14 per cent of that oxygen is transferred into the circulatory system and is used. A lung in average condition will make use of 19 per cent of the inspired oxygen. An individual who is in excellent condition will use 23.8 per cent of the oxygen supply.

If a lung is in good condition, rather than in poor condition, it will carry a 10 per cent increased oxygen supply, and will keep the heart and all other parts of the body supplied with oxygen more easily.

Exercise also aids in weight reduction. If an overweight individual participates in a three- to five-day-per-week exercise program, he or she will find fat turning into muscle fibre, and will note some weight reduction. If a combination of diet and exercise is used, a greater rate of weight loss will be noted. If more calories are burned up than are taken in, weight reduction has to occur, even though it is very small. Exercise strengthens the heart, improves the efficiency of the lungs, aids in weight control, and also makes one sleep better, eat better and enjoy better spirits, with the result that his work efficiency improves.

There are four basic categories of exercise: (1) Isometrics involve contracting one set of muscles against another, or against an immobile object. (Major Cooper defined isometrics as great exercises for developing muscles to do isometrics!) (2) Isotonics produce motion, as in calisthenics, without demanding much oxygen. (3) Anaerobics demand so much oxygen so rapidly that an oxygen debt is incurred which one must pay at once by stopping to recover. Dashes and wind sprints are such exercises. (4) Aerobic exercises "with oxygen"—are the basis for endurance-fitness training. They demand oxygen without producing an intolerable debt, and can be continued for long periods of time.

With exercise vigorous enough to produce a sustained heart rate of at least 150 beats per minute, training-effect benefits begin after about five minutes, and continue for as long as the exercise continues. Less vigorous exercise for a longer period may also produce training-effect benefits.

Many people who come to a fitness program will not be in the best physical condition, and one of the temptations they must avoid is to seek instant fitness. The best advice they can be given is to work each time just beyond the point of comfort, thus extending the frontier of capability. Exercise must be undertaken at least three days per week if one is to continue his progress toward endurance fitness. Fox and Haskell,* from their extensive work in this field, state that the results of five days per week of adequate exercise is very little greater than what can be accomplished in three days per week. The incidence of orthopedic problems, however, is significantly greater with the five-day than with the three-day exercise program.

The specific form that aerobic exercise takes depends upon the facilities available at any given time or place, and upon the preference of the instructor. Calisthenics should be used to "warm up" and, after exercise, to "warm down." The aerobic exercise itself may consist of jogging, walking, running, swimming, cycling, playing handball, basketball or squash, rowing, canoeing, rope skipping, or engaging in some combination of these activities. Other sports which *do not* qualify are those which are aimed solely at skeletal muscles or which require spurts of effort so that no steady-state exertion results.

Much appears in the press about the need for exercise, and at this point the public has been

* Dr. Samuel M. Fox, III is chief of the Heart Disease and Stroke Control Program of the U. S. Public Health Service, and Dr. Wm. L. Haskell is director of program development for the President's Council on Physical Fitness and Sports.

convinced and wants to flex its muscles. Many exercise programs are being conducted in Iowa under the auspices of the YMCA, the Iowa State Department of Public Instruction and the Iowa State University Extension Service, as well as the private health clubs. The total number of people involved is unknown, but in 1969 the 27 YMCA's had over 1,000 men and women involved—about 800 in jogging and about 400 in swimming. It appears that the best contribution the Iowa State Department of Health can make to this effort to improve the physical and mental well being of Iowans is to urge the use of aerobic exercise in programs; to distribute information for instructors and participants on the rationale of exercise, emphasizing the importance of proper diet and the relationship between caloric intake and caloric output; and to persuade smokers of the importance of breaking their habit.

We hope to have dietitians participate actively in the program. A well balanced and proportioned diet is an important part of an exercise program. Participants in an exercise program should know what calories are, how they are used, and how many of them one needs per day. A knowledge of how many calories different foods contain, and also of the energy expenditure rate per hour for various activities will enable the participant to gauge his activities as well as his diet.

If one adds 30 minutes per day of moderate exercise to one's schedule, a loss of about 25 lbs. in one year will occur if food consumption remains constant. One added slice of bread or one bottle of a soft drink per day adds up to 10 lbs. per year, if no additional exercise is begun that will counter the caloric increase.

We stress the need for medical clearance before exercising and the desirability of evaluating the participant's fitness before and after he takes part in the clinic. We hope that, as participants realize how much an adequate exercise program improves their physical and mental health, they will be motivated to continue on their own, with or without supervision.

Morbidity Report for Month of January, 1970

Disease	Jan. 1970	1970 To Date	1969 To Date	Most Jan. '70 Cases Reported From These Counties
Adenovirus	3*	3*	1	Johnson, Story, Woodbury
Brucellosis	2	2	0	Dubuque
Chickenpox	1101	1101	787	Black Hawk, Wright
Encephalitis				
Echo 4	2	2	0	Story, Wapello
Echo 6	2	2	0	Black Hawk, Fayette
Mumps	1	1	0	Bremer
German Measles	256	256	183	Black Hawk, Linn, Woodbury
Gonorrhea	346	346	288	Black Hawk, Linn, Polk, Scott
Histoplasmosis	3*	3*	2	Hardin
Impetigo	64	64	34	Cherokee, Polk
Infectious hepatitis	35	35	53	Dubuque, Pottawattamie, Woodbury
Infectious mononucleosis	59	59	54	Johnson
Influenza A2	7†	7†		Appanoose, Black Hawk, Johnson
Leptospirosis	1*	1*	1	Davis
Malaria, imported				
P. falciparum	2*	2*	0	Jasper, Washington
P. vivax	1*	1*	3	Keokuk
Meningitis				
Echo 3	2	2	0	Decatur, Polk
Echo 4	1	1	0	Dubuque
Group C	1	1	0	Jefferson
type unspecified	2	2	0	Marshall, Pottawattamie
Meningo-encephalitis	4	4	0	Allamakee, Cerro Gordo, Dubuque, Wright
Mumps	336	336	806	Black Hawk, Dubuque, Mitchell, Pottawattamie
Pneumonia	70	70	35	Pottawattamie
Rabies in animals	7	7	7	Scattered
Rheumatic fever	4	4	5	Pottawattamie
Salmonellosis				
S. chester	1	1	2	Winneshiek
S. infantis	1	1	1	Wapello
S. newport	1	1	5	Polk
S. oranienburg	1	1	0	Sioux
S. saint paul	1	1	0	Polk
S. typhimurium	3	3	3	Jasper
S. typhimurium var. copenhagen	1	1	1	Pottawattamie
Shigellosis, S. sonnei	16	16	2	Scattered
Streptococcal infections	706	706	530	Johnson
Syphilis	40	40	55	Polk
Tuberculosis, active	9	9	15	Linn
Typhoid Fever	1*	1*	0	Polk
Whooping cough	3	3	0	Appanoose, Pottawattamie, Tama

* Delayed

† A-2 influenza virus recovered

Camp Hertko Hollow

Iowa's Camp for Diabetic Youth Established Summer of 1968

Purpose: Provide camping opportunities and experiences for juvenile diabetics, ages 8 through 15, from throughout Iowa whose doctors feel they are well enough controlled to attend.

Staff: The staff includes physicians, student nurses, registered nurses, dietitians, home economists, educators, naturalists, water front specialists and other interested lay personnel, all of whom form a team approach in serving as counselors and instructors throughout the camp session.

Activities: Activities at Camp Hertko Hollow include: hiking, swimming, archery, trampolines, nature studies, crafts, canoeing, softball, fishing, cookouts, skits, singing and campfires. Other educational aspects of the camp include lesson-discussions led by nurses and dietitians concerning the health aspects of giving one's own injection, an insulin reaction, cleanliness and care of equipment, etc. The dietitians supervise each diet and discuss foods and wise ways to plan for variety in the daily diet.

Location: The setting for Iowa's camp for diabetic youth is the State 4-H Camping Center near Madrid.

Dates: The dates are from Sunday afternoon, July 26 through Saturday afternoon, August 1, 1970.

Cost: The cost will be $60 per child for the six days, payable by June 1. Applications, on a first come-first served basis, are due by June 1.

Sponsors: The camp is sponsored by the Iowa Diabetes Association, Iowa Dietetic Association, and Iowa State Department of Health.

For more information contact your school nurse, the public health nurse in your area, or write or phone

Camp Hertko Hollow
c/o Chronic Illness and Aging Service
Iowa State Department of Health
Robert Lucas Office Building
Des Moines, Iowa 50319
Telephone: (515)-281-5442

The Doctor's Business

(Continued from page 196)

aries, supplies and other necessities in line and reasonable? Is his net income reasonable for the time and effort he is expending? Is it increasing with other segments of our economy?

There are pitfalls in the use of averages and other statistics. Figures must be put into the proper frame of reference. You can't compare apples and oranges. Averages can be meaningless. Take, for example, a man who has his head in the refrigerator and his feet in the oven, but *on the average* his temperature is about normal.

Iowa Association of Medical Assistants

(Continued from page 198)

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Sioux City, Iowa
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1970 ANNUAL MEETING IOWA MEDICAL SOCIETY

- *Monday, April 27: Clinical Problems Confronting the Physician*
- *Tuesday, April 28: Survival on Earth, in Space, Under Water*
- *Exhibits / Luncheon Sessions / President's Reception / Medical Alumni Reunion Annual Banquet / Specialty Group Dinners*

NOTE: Sunday, Monday, and Tuesday Sessions to be held at Hotel Fort Des Moines; Wednesday Session, Hotel Savery.

— APRIL 26 to 29 — DES MOINES, IOWA

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Personals



Dr. F Harold Entz, of Waterloo, was re-elected president of the Waterloo Visiting Nurses Association at the group's annual meeting held on Thursday, January 8. **Dr. C. W. Seibert,** also of Waterloo, was re-elected to a three-year term on the VNA board.

Dr. Richard H. Bobenhouse, of Newton, began a two-year residency in anesthesiology at the U. of I. in early January. Dr. Bobenhouse has been associated with **Drs. R. F. Frech** and **D. R. Onnen** at Medical Associates for nearly three years.

Dr. R. L. Bartley has been reappointed Audubon County medical examiner. He has held his post since it was created by the General Assembly of Iowa several years ago, and previous to that time he had been the Audubon County coroner. The board of supervisors also has reappointed **Dr. H. K. Merselis** deputy medical examiner.

At the suggestion of **Dr. W. E. Owen,** of St. Ansgar, who recently returned from his second tour of duty with the AMA Volunteer Physicians for Vietnam, the Osage Kiwanis Club conducted a drive to gather clothing items for Vietnamese children.

At the annual meeting of the Jasper County Medical Society, in January, **Dr. J. L. Walker** was elected president; **Dr. Roy Sloan,** vice-president; and **Dr. Erwin Wittenberg,** secretary-treasurer. **Dr. R. F. Frech** was named delegate to the Iowa Medical Society, and **Dr. F. E. Forsythe,** alternate. All of them practice in Newton.

Dr. Robert E. Votteler, a Marshalltown psychiatrist, addressed the Child Study Group there, on January 8. His topic was "How to Better Your Child's Personality."

At the annual meeting of the Polk County Medical Society, at Hotel Fort Des Moines on January 21, **Dr. Homer E. Wichern** was named president-elect; **Dr. Ralph E. Hines** was installed as president; **Dr. James J. Kelso** was elected secretary-treasurer; **Dr. Donald J. Schissel** was named to a five-year term as trustee; and **Dr. Donald F. McBride** was made counselor for a three-year term. The Polk County Medical Society pledged a $1,000 contribution to the Polk County-Des Moines Health Department to help finance rubella immunizations.

Rev. Dr. Paul D. McCleave, head of the AMA Department of Medicine and Religion, spoke on "Medicine and Religion" at the St. Luke's United Methodist Church, Dubuque, on February 10. **Dr. Donovan F. Ward,** a Dubuque surgeon and a past-president of the AMA, presided at the meeting.

A certificate for 10 years' service and a lapel pin were presented to **Dr. E. B. Getty,** of Primghar, January 8, by the American Cancer Society, Iowa Division, Inc.

Representatives of the Mahaska County Medical Society, **Dr. Lawrence Grahek** and **Dr. Sidney Smith,** appeared before the Oskaloosa City Council on January 19 to advocate the passage of an ordinance that would limit the "noise level" at teenagers' dances there. Dr. Smith was quoted as reporting: "The era of the teenager and his amplifier could usher in hearing difficulties. . . . Ninety decibels, as measured on a standard meter is a desirable limit."

Dr. Maurice D. Schnell, an assistant professor of orthopedic surgery at the U. of I. College of Medicine, and **Dr. James A. Pearson,** of Dubuque, were inducted as fellows of the American Academy of Orthopedic Surgeons, in mid-January, in Chicago.

At the January 19 meeting of the Boone County Registered Nurses Association, **Dr. Ralph L. Wicks**, of Boone, was the guest speaker. He described his experiences in Belgium, Sweden, Russia and Czechoslovakia, last summer.

Dr. Harold Margulies, an internist who practiced in Des Moines from 1949 to 1961, has been appointed deputy assistant administrator of planning and evaluation for the Mental Health Administration of USPHS, with offices in Rockville, Maryland. Since leaving Iowa, Dr. Margulies has supervised medical education in Pakistan, and for the past two years he has been secretary of the AMA Council on Health Manpower and has coordinated that agency's activities with those of the executive branch of the federal government.

During his second, recently-completed two-months' service with the AMA Volunteer Physicians for Vietnam, **Dr. W. E. Owen,** of St. Ansgar, says he noticed a considerable difference in attitude between the delta Vietnamese whom he treated during his 1966 tour of duty and the Quang Ngai people whom he served this time. Quang Ngai is in the northern part of the country, near the DMZ, and his patients there were harder to make friends with, probably because of the stronger Viet Cong influence there. An article in the January 17 MASON CITY GLOBE-GAZETTE said he had picked up enough of the Vietnamese language in 1966 so that he could converse with his patients to some extent during his more recent trip there.

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Dr. Harold W. Morgan, a Mason City pathologist and for 30 years a central figure in the American Cancer Society, Iowa Division, Inc., announced on January 14 that he was retiring from practice. One of his principal accomplishments was his pioneering the use of blood-alcohol measurements for the determining of intoxication. He and **Mrs. Morgan** have served twice, within the past few years, on the staff of the hospital ship *Hope*.

Dr. K. R. Cross recently arranged a display of hospital-laboratory equipment, some of it dating back to the early 1900's, at Mercy Hospital, Iowa City. Some statistics relating to Mercy Hospital's laboratory, 50 years ago and now, were no less interesting than the equipment on display. In or about 1920, the laboratory consisted of a room with just 350 sq. ft. of floor area and a single technician ran it; now the laboratory has a working area of 3,500 sq. ft., and its staff includes about 20 technologists.

At the annual meeting of the medical staff of Stewart Memorial Community Hospital, in Lake City during January, **Dr. Dale L. Christensen** was reelected chairman; **Dr. Paul Ferguson** was reelected vice-chairman, and **Dr. Ashton McCrary,** secretary.

Dr. Frederick Lohr, of Sioux City, participated in a seminar on narcotics at Heelan High School, there, on January 16. Two films on drug use and abuse were shown.

Dr. Mary A. Croker, of Manchester, took part in a panel discussion at a parent-education session there, on January 19. The program was designed to help parents prepare four-, five- and six-year-olds for kindergarten and early learning experiences.

On January 24 and 25, in Iowa City, **Dr. A. E. Braley** and **Dr. Frederick C. Blodi,** together with a considerable perimedical staff, conducted the third in a series of short courses designed to train morticians to remove eyes and to prepare them for transportation to institutions where the corneas can be used to restore the vision of sightless persons. There have been occasions where eyes were available but physicians could not remove them in time for them to be used in the eye-bank

program. It is hoped that instruction of this sort can be made a part of initial training courses for morticians. Dr. Braley is a professor emeritus of ophthalmology at the U. of I. now engaged in private practice, and Dr. Blodi is head of the U. of I. Department of Ophthalmology.

Dr. Alfred Healy, an assistant professor of pediatrics at the U. of I. College of Medicine, and a member of the staff of the Iowa Hospital School, has been elected chairman of the Iowa Chapter of the American Academy of Pediatrics.

The 1970 officers chosen at the recent annual meeting of the Clinton County Medical Society are **Dr. G. L. York,** president; **Dr. K. R. Sorenson,** vice-president; and **Dr. Margaret Emmons,** secretary-treasurer. The Clinton County delegates to the Iowa Medical Society are **Drs. K. R. Sorenson** and **G. T. Schmunk.**

About 50 pathologists and medical technologists from the states of Kansas, Minnesota, Nebraska, Arkansas, Colorado, Illinois, Missouri and Iowa attended a regional seminar on parasitology on January 30 and 31 at the Holiday Inn, Waterloo. **Dr. James Collins,** a Waterloo pathologist was a co-chairman of the arrangements committee. The guest speakers included **Dr. Clyde Swartzwelder,** a professor of medical parasitology at the Louisiana State University Medical Center.

Dr. W. E. Erps, who has practiced medicine for the past eight years in Storm Lake, announced on January 15 that he intended leaving at the end of that month to join the staff of the Veterans Administration Hospital in Grand Junction, Colorado.

Dr. John H. Spencer, who had practiced surgery in Muscatine for 13½ years, closed his office there on January 31 with the intention of joining a nine-man group of doctors in Streator, Illinois.

Dr. David M. McCoy, who recently completed his residency in radiology at University Hospitals, Iowa City, joined the staff of the McCrary-Rost

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Clinic, in Lake City, on January 2. He received his M.D. at the University of Iowa in 1965, entered military service and took his internship at Madigan Army Hospital, in Tacoma. Subsequently he was stationed in Germany and in Oakland, California. He and Mrs. McCoy have two sons.

On January 17 **Dr. P. J. Cusack,** who has practiced radiology at Skiff Hospital, Newton, for the past eight years, announced that he would leave there on March 1. He is a diplomate of the American Board of Radiology, and presently is on the executive committee of the Iowa Radiological Society. He did not announce his plans.

Dr. Albert L. Clemens is chief of staff at Des Moines Mercy Hospital for 1970. **Dr. John J. Polich** has been named chief-of-staff elect, and **Dr. James Skultety** is secretary-treasurer. Dr. Clemens succeeds **Dr. Austin E. Schill.** All of those men practice in Des Moines.

Dr. Rodney R. Carlson has been made chief of staff at Broadlawns-Polk County Hospital, Des Moines. He has practiced in Ankeny for six years.

The medical staff officers at Xavier Hospital, Dubuque, for 1970 are **Dr. Paul B. Skelley,** president; **Dr. Joseph Heller,** vice-president; and **Dr. Paul Pechous,** secretary.

The Mahaska County Board of Supervisors has reappointed **Dr. G. W. Bennett,** of Oskaloosa, medical examiner.

Dr. Robert Votteler, a Marshalltown psychiatrist, was one of the panelists in a discussion on the use and abuse of drugs held at Marshalltown Community College on February 12. The meeting was open to the public.

Dr. Albert P. McKee, a faculty member in the Department of Microbiology at the U. of I. College of Medicine for 30 years, resigned recently to become director of a new division of the Ortho Research Foundation, in Raritan, New Jersey. There, he will continue his research on infectious hepatitis and other studies.

The guest speaker at the January 27 meeting of the Clover Hills P.T.A., in West Des Moines, was **Dr. John Gustafson,** a Des Moines pediatric cardiologist. His topic was "Heart Disease in Children."

Dr. Larry H. Boeke, of West Union, has been elected president, for 1970, of the board of directors of the Cedar Valley Mental Health Center. This is the second year of Dr. Boeke's board membership. The Center is located in Waverly.

Dr. Dennis Olsen represented the medical profession in a panel discussion of the drug-abuse problem sponsored by the New Hampton Jaycees on January 28.

The Jefferson County Board of Supervisors has reappointed **Dr. C. F. Watson** county medical examiner, and **Dr. Ludwig Gittler,** doctor for the County Home.

Dr. Herbert Tjaden, a urologist, has been elected president of the medical staff of Burlington Memorial Hospital for 1970. The vice-president is **Dr. Ralph Rettenmaier,** a pathologist, and the secretary is **Dr. Jo Ellen Hoth,** a general practitioner.

Dr. C. V. Murphy has asked the Alton Junior Chamber of Commerce to cancel the "Appreciation Day" that it was planning to conduct for him. Dr. Murphy said he plans to practice a few more years. "Maybe they can have one when I retire," he said, "But I'm not ready to quit yet."

Fifteen physicians attended a one-day training program on coronary care at John McDonald Hospital, Monticello, late in January. It was presented by **Drs. Donald Warkentin** and **Ernest Theilen,** of the U. of I. College of Medicine, under the auspices of the Iowa Regional Medical Program.

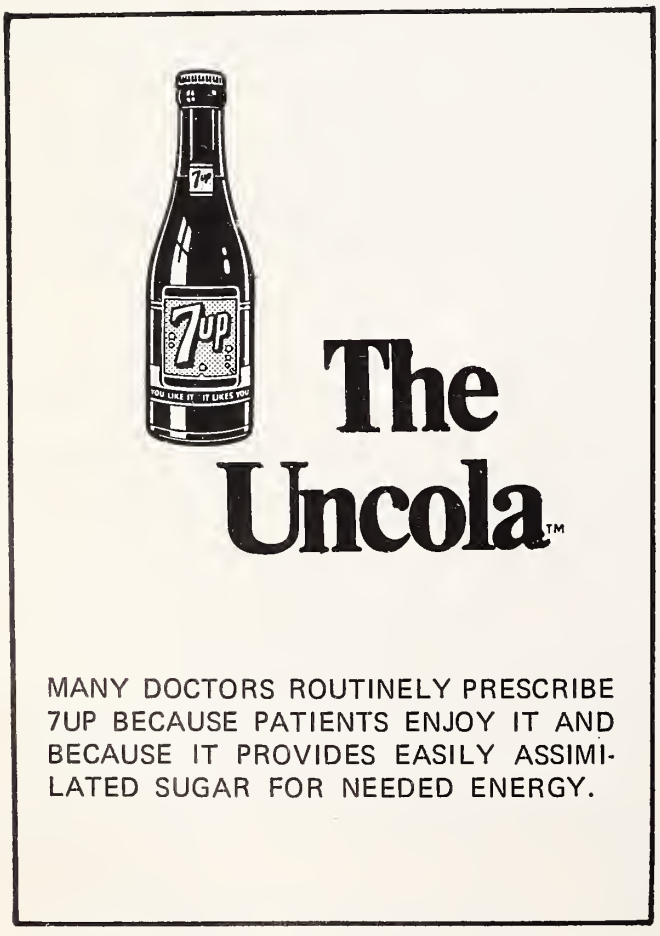
The Wapello County Medical Society held its February 3 meeting at the Red Lyon Inn, in Ottumwa. The guest speaker, **Dr. T. M. Sundt, Jr.,** from the Section of Neurologic Surgery at the Mayo Clinic, spoke on "Intracranial Aneurysms and Subarachnoid Hemorrhage."

Dr. Curtis G. Wuest, a Marshalltown general practitioner, spoke to the Marshall County Child Study Group, February 4, on "The Health of Your Child." On that same day, **Dr. John E. Sinning,** another Marshalltown physician, spoke to the Marshalltown Woman's Club about his and his wife's experiences in the Cumberland Mountains of Kentucky, where they worked on behalf of an Evangelical United Brethren Mission.

Dr. Mark D. Ravreby has been elected chief of staff at Northwest Hospital, Des Moines. **Dr. Don C. Green** was elected vice-president, and **Dr. Charles Johnson,** secretary-treasurer.

The centennial of the U. of I. College of Medicine is to be marked by a number of observances, most of them during the week of September 14 to 19, next fall. The April (University) issue of this JOURNAL is to contain some materials concerning it, and announcements regarding conferences, symposia and reunions to be held next fall. Faculty-member physicians on the Centennial Committee are **Jack Moyers, M.D.,** chairman, **Rubin H. Flocks, M.D., Lewis E. January, M.D.,** and **Christian Radcliffe, M.D.** Other doctors who are serving on the Centennial Committee include **Christian E. Schrock, M.D.,** Iowa City, **Cecil W. Seibert, M.D.,** Waterloo, **William M. Krigsten, M.D.,** Sioux City, **John H. Sunderbruch, M.D.,** Davenport, and **Kenneth E. Lister, M.D.,** Ottumwa.

At the February 18 meeting of the Polk County Medical Society, **Dr. John C. MacQueen,** a professor of pediatrics and an associate dean of the U. of I. College of Medicine, spoke on "Education for General Practice in Iowa."



Dr. Terry J. Sutton, a 1966 graduate of the University of Kansas Medical School who served his internship at the hospitals in Cedar Rapids, and one year of a residency in surgery at Grosse Pointe, Michigan, has agreed to join **Drs. K. H. Strong, R. A. Ryan** and **G. E. Egli** in general practice at Fairfield late next summer. He will complete his military service at Grissom Air Force Base, Peru, Indiana, on August 13.

Drs. William E. Connor and **Harold P. Schedl,** both professors of internal medicine at the U. of I. College of Medicine, have been named co-editors of the JOURNAL OF LABORATORY AND CLINICAL MEDICINE. **Dr. Francois Abboud,** another professor in the same department, is to be associate editor. It is the official publication of the Central Society for Clinical Research.

Dr. Robert G. Collier, a 1958 graduate of the University of Illinois College of Medicine who completed a residency in surgery at University Hospitals, Iowa City, in 1965, and since then has been practicing his specialty in Helena, Montana, has joined the Northwest Medical Group, at 430 West Thirty-fifth Street, Davenport.

At the April 12-17 annual meeting of the American College of Physicians, in Philadelphia, one of 13 doctors elevated to Masters of the College is **Dr. Willis M. Fowler,** of Iowa City, an emeritus professor of internal medicine at the U. of I. College of Medicine.

Dr. Ronald F. Maly, a 1962 graduate of the Creighton University School of Medicine who was in general practice for several years in Des Moines after interning at Mercy Hospital there, has become a plant physician for the Humble Oil and Refining Company, at Baytown, Texas. He recently was granted a master's degree in occupational medicine by the University of Oklahoma Medical School.

Dr. Paul B. Skelley has been elected president of the medical staff at Xavier Hospital, Dubuque, for 1970. **Dr. Joseph Heller** has been named vice-president, and **Dr. Paul Pechous,** secretary. All of them practice in Dubuque.

Dr. William B. Bean, head of internal medicine at the U. of I. College of Medicine, is the author of a commentary on one of the essays in WILLIAM OSLER, THE CONTINUING EDUCATION, which has been published on the fiftieth anniversary of Osler's

death. His comments follow Osler's essay "On the Influence of a Hospital Upon the Medical Profession of a Community," which explained and defended the newly-introduced practice, at Johns Hopkins, of letting medical students render patient care on the wards, rather than merely follow faculty-member physicians as they made their rounds.

Dr. Richard Fincham, an associate professor of neurology at the U. of I. College of Medicine, was the principal speaker at the February 4 meeting of the Johnson County Medical Society. The gathering took place at the University Athletic Club, in Iowa City, and he spoke on "Use of L-DOPA in Parkinsonism."

The 1970 officers of the Crawford County Hospital medical staff are **Dr. T. S. Hutcheson**, of Denison, president; **Dr. T. C. White**, of Denison, vice-president; and **Dr. J. M. Hennessey**, of Manilla, secretary-treasurer.

Dr. Warren H. Bower, of Grinnell, has been certified by the American Board of Surgery.

The Knoxville Chamber of Commerce, on January 26, named **Dr. Dwight Mater** the recipient of its 1969 Community Service Award. He was given a plaque emblematic of the honor. Dr. Mater has practiced in Knoxville for 35 years, and was cited for his work on behalf of Collins Memorial Hospital, his service as chairman of the Knoxville Planning and Zoning Commission, his leadership in Rotary, his membership on the board of directors of the Area XI Community College and his membership on the Knoxville Board of Education. A reception in his honor was held following the meeting.

A Cedar Rapids psychiatrist, **Dr. W. J. Moershel**, has been named psychiatric consultant for the public schools there. Like those of **Dr. Marian Barnes**, who is medical consultant to the Cedar Rapids Public Schools, Dr. Moershel's duties will not include direct services to students.

Dr. Dean Nierling was named the Cresco Jaycees' "Man of the Year" at a ceremony on January 26. In introducing Dr. Nierling, **Dr. Larry Boeke** pointed to the honoree's special interest in both the public and the parochial school systems, and praised him for "causing people to think" concerning the educational programs. Dr. Nierling is a graduate of Cresco High School and of the U. of I. College of Medicine, and he has taken postgraduate work in surgery at the University of Missouri.

On January 19 **Dr. Norman L. Krueger**, of Casey, was elected chief of the medical staff for the coming year at the Guthrie County Hospital. **Dr. D. W. Todd**, of Guthrie Center, and **Dr. C. A. Nicoll**, of Panora, were chosen to fill the other staff offices.

Dr. Howard H. Gessford, of George, has been appointed Lyon County medical examiner, and **Dr. Carl V. Griesy**, of Rock Rapids, has been named his deputy.

Dr. Arthur Pedersen, the Pottawattamie County medical examiner, notified the board of supervisors, on January 22, that he wished to name four Council Bluffs deputy ME's—**Dr. Edward R. Farrage, Dr. Lynn Leibel, Dr. Emmett Mathiasen** and **Dr. Robert Westfall**—and four for the outlying parts of the County—**Dr. Rafael Roure**, of Glenwood, **Dr. Max Olsen**, of Minden, **Dr. Anthony Romano**, of Neola, and an Oakland osteopath. The supervisors had requested that he appoint his own deputies.

The adults and young people of Lone Tree heard a discussion of the use and misuse of drugs, on February 8, by **Dr. Robert M. Bittle**, an assistant professor of psychiatry at the U. of I. College of Medicine.

Dr. Ada Perel, a Des Moines psychiatrist, spoke at the February meeting of the Des Moines Claims Association, on the subject of suicide. Dr. Perel, after a year of semi-retirement, has reopened her office at 4309 Holland Drive, Des Moines.

For the Paul Rhodes Press Conference on February 2, over KRNT-TV, the guests were two Des Moines internists, **Dr. Herman J. Smith** and **Dr. Lawrence Staples**. They answered phoned-in questions regarding heart disease.

Dr. John H. Sunderbruch, of Davenport, president-elect of the Iowa Medical Society, was the guest speaker at the IMS headquarters building in West Des Moines, February 10, when the Woman's Auxiliaries to the Iowa and Polk County Medical Societies entertained the wives of legislators and state executives at a continental breakfast. His topic was "Medicine Behind the Iron Curtain."

Dr. Mark Ravreby, a Des Moines internist, and **Dr. John Hege**, a Des Moines psychiatrist, have been appointed adjunct professors by Drake University. Dr. Ravreby, who holds not only an M.D. from the U. of I. but also a J.D. degree from

Drake, is currently teaching a course in law and medicine at the Drake Law School. Dr. Hege, a psychiatric consultant at the State Training School for Girls, in Mitchellville, assists the Law School faculty in courses dealing with corrections, and criminal and juvenile law.

The Mid-Eastern Iowa Community Mental Health Center, in Iowa City, was dedicated on Sunday, February 22, though it has been in operation since December 1, 1969, at 302 Gilbert Street, opposite the Recreation Center. **Dr. Herbert L. Nelson,** a professor of psychiatry at the U. of I. and head of the Iowa Mental Health Authority, is serving as its acting medical director.

Dr. Leslie Bernstein, a professor of otolaryngology and maxillofacial surgery, at the U. of I. College of Medicine, had a share in a panel discussion at the sectional meeting of the American College of Surgeons, in St. Paul on February 16.

At a program on "Family Heart Care" for the Mothers' Study Unit in Newton, early in February, **Dr. Harold A. Van Hofwegen** presented a film on congenital heart defects and spoke on general heart care.

Dr. Erwin M. Wittenberg, of Newton, has been elected to active membership in the Iowa Chapter of the American Academy of General Practice.

Deaths

Dr. John K. Dickinson, 38, a psychiatrist who resigned last summer from the superintendency of the Iowa security medical facility at Oakdale, died on January 15 in Coralville. He had joined the staff of the old security medical facility at the Men's Reformatory at Anamosa in 1965.

Dr. L. W. Clark, 83, a retired physician who had made his home with his son, Dr. R. E. Clark, of Manchester, for the past 10 years, died at the Delaware County Hospital, there, on January 14, following a brief illness. A 1909 graduate of the U. of I. College of Medicine, he practiced in Chester, Iowa for 20 years, from 1913 to 1933. Subsequently he practiced in Spring Valley, Minnesota for 27 years.

Dr. Peter R. Meis, 68, who practiced in LeMars in the 1930's before moving, successively, to Omaha and to Tucson, died in Tucson on October 31, 1969. He took his M.D. degree at the U. of I. in 1926. Illness necessitated his moving to the Southwest, but there he regained his health sufficiently to permit his serving as chief of medicine at Davis-Monthan Air Force Hospital. He was on the staff there at the time of his death.

Dr. Edward L. Rohlf, Jr., 59, a Waterloo surgeon, died at his home on January 25, following a heart

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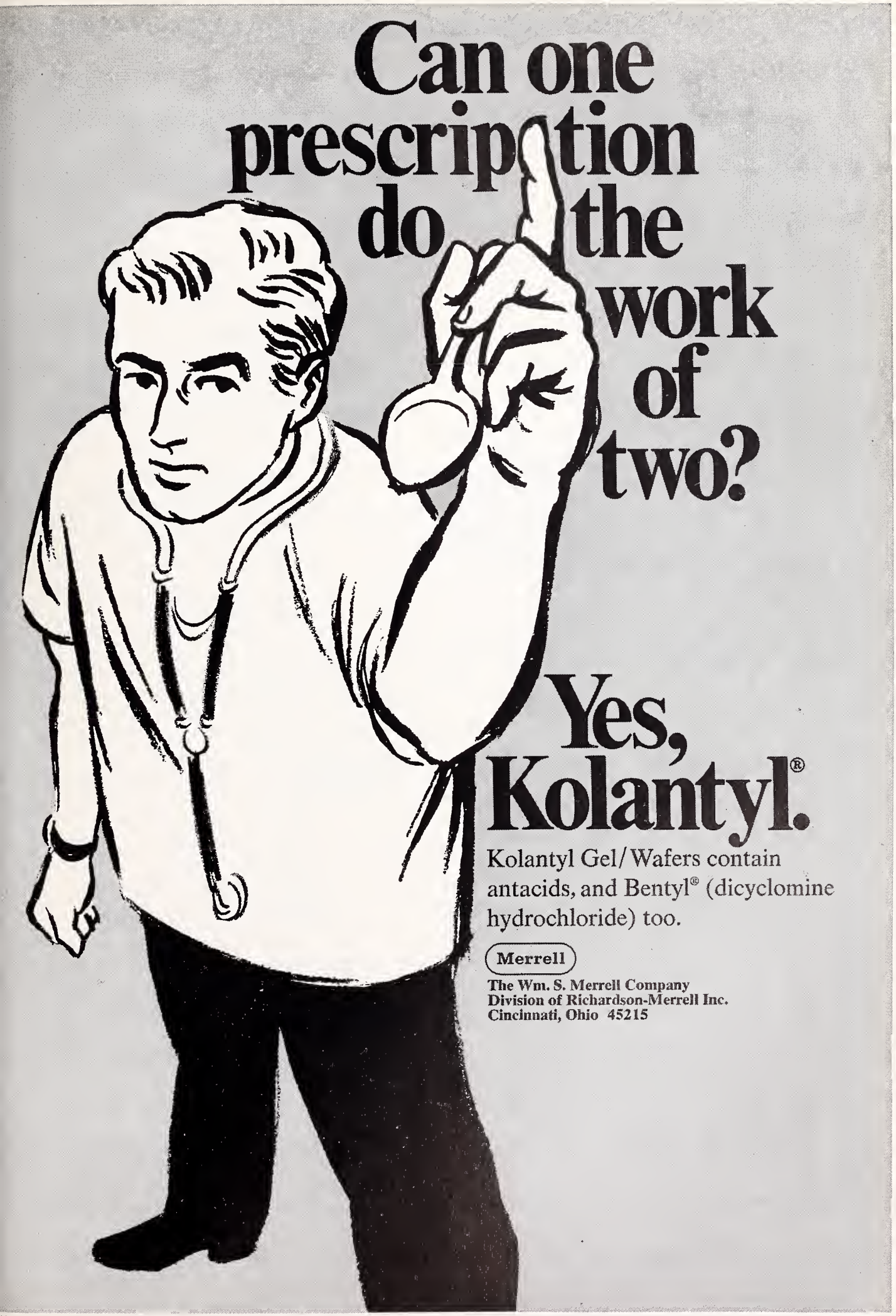
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attack. His boyhood home was in Waterloo; he received his medical degree at the University of Iowa College of Medicine in 1938; he interned in Cleveland; and he practiced in Waterloo from 1940 until his death, except for a few years of military service during World War II.

Dr. Robert R. Hansen, 86, a Marshalltown physician and surgeon who only recently retired, died at Marshalltown Community Hospital East, on January 25, a few days after incurring a hip fracture. He received his medical degree from the University of Illinois, and began practice in Marshalltown in 1909 following an internship in Chicago. He was a Life Member of the Iowa Medical Society.

Dr. George W. Rowney, 49, who had practiced obstetrics and gynecology in Sioux City since 1952, died at a motel in Overland Park, Kansas, on February 1 or 2. He received his M.D. degree in 1946 from Hahnemann Medical College, in Philadelphia, he interned at Huron Road Hospital, Cleveland, and served his residency there and at Western Reserve University. During World War II, he had served in the Navy Air Force.

Dr. Charles E. Decker, 60, died on February 7 at his home in Davenport. He did his premedical work at Dartmouth College, and received his M.D. from the U. of I. College of Medicine in 1939. He interned in Montreal, and served with the Army Air Force during World War II. In 1946 he opened his general practice in Davenport.

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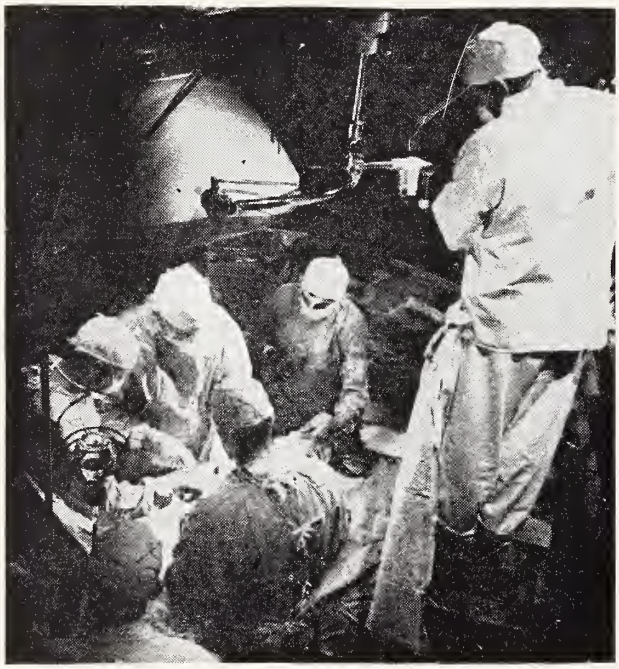
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Index to Advertisers

American Medical Association 191, 222
American Tobacco Company 197
Arch Laboratories 210

Burroughs-Wellcome & Co. 190B

Campbell Soup Company 184A
Casualty Indemnity Exchange 223

Hynson, Westcott & Dunning, Inc. 147

Lederle Laboratories 149, 190A
Lilly, Eli, & Company 145, 170

Medical Protective Company 216
Merck, Sharp & Dohme 150-152
Merrell, William S., Company 217

National Drug Company 146, 178A, B
National Safety Council 212

Parke, Davis & Company 184D, 214A
Polk County Medical Society 203
Poythress, Wm. P., & Company 214D
Prouty Company 211

Robins, A. H., & Company 169, 206A, B
Roche Laboratories 224

Searle, G. D., & Company 184B, C
Seven-Up Bottlers of Iowa 214
Silver Shield Plan 207
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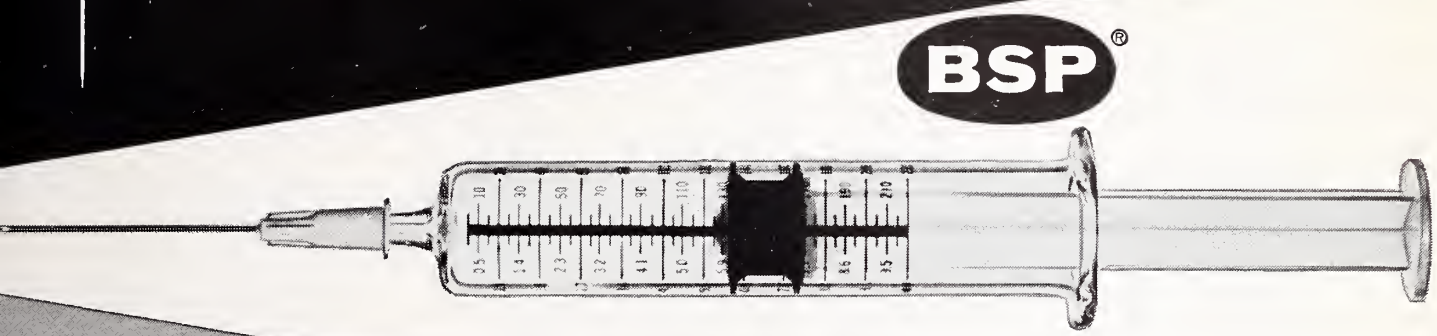
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Vol. LX APRIL, 1970 No. 4

CONTENTS

Greetings From the Office of the Dean 236

The University of Iowa College of Medicine: 100 Years Ago
William B. Bean, M.D. 237

SCIENTIFIC ARTICLES

Kidney Transplantation in Iowa: A Progress Report
William W. Bonney, M.D. 247

Tuberculosis and Bronchogenic Carcinoma
N. P. Rossi, M.D., P. R. Recinos, M.D., and J. L. Ehrenhaft, MD 255

Vasodilators in Prevention and Treatment of Ischemic Stroke
John R. Taylor, M.D. 258

EDITORIALS

A Century of Distinguished Service 263

Iowa Physicians Analyze Rear-End Collisions . 263

Azothioprine in the Treatment of Thrombocytopenic Purpura 264

When Is Mastoidectomy Necessary? 266

Discipline: A Central Issue of Our Times . . . 267

SPECIAL DEPARTMENTS

The Month in Washington 230

Coming Meetings 234

President's Page 262

In the Public Interest facing page 262

Information from the Iowa Heart Association: "Newer Concepts of Evaluation of Cardiac Function"
William W. Parmley, M.D., and Edmund H. Sonnenblick, M.D. 269

Iowa Association of Medical Assistants 273

State Department of Health 277

Doctor's Business 280

Woman's Auxiliary News 281

Personals 285

Deaths 290

MISCELLANEOUS

In the Wisdom of Congress 233

College of Medicine Admission Requirements . 240

College of Medicine Recognizes Preceptors . . 241

Educational Opportunity Program in College of Medicine 271

New Pamphlet Explains AMA to Public . . . 274

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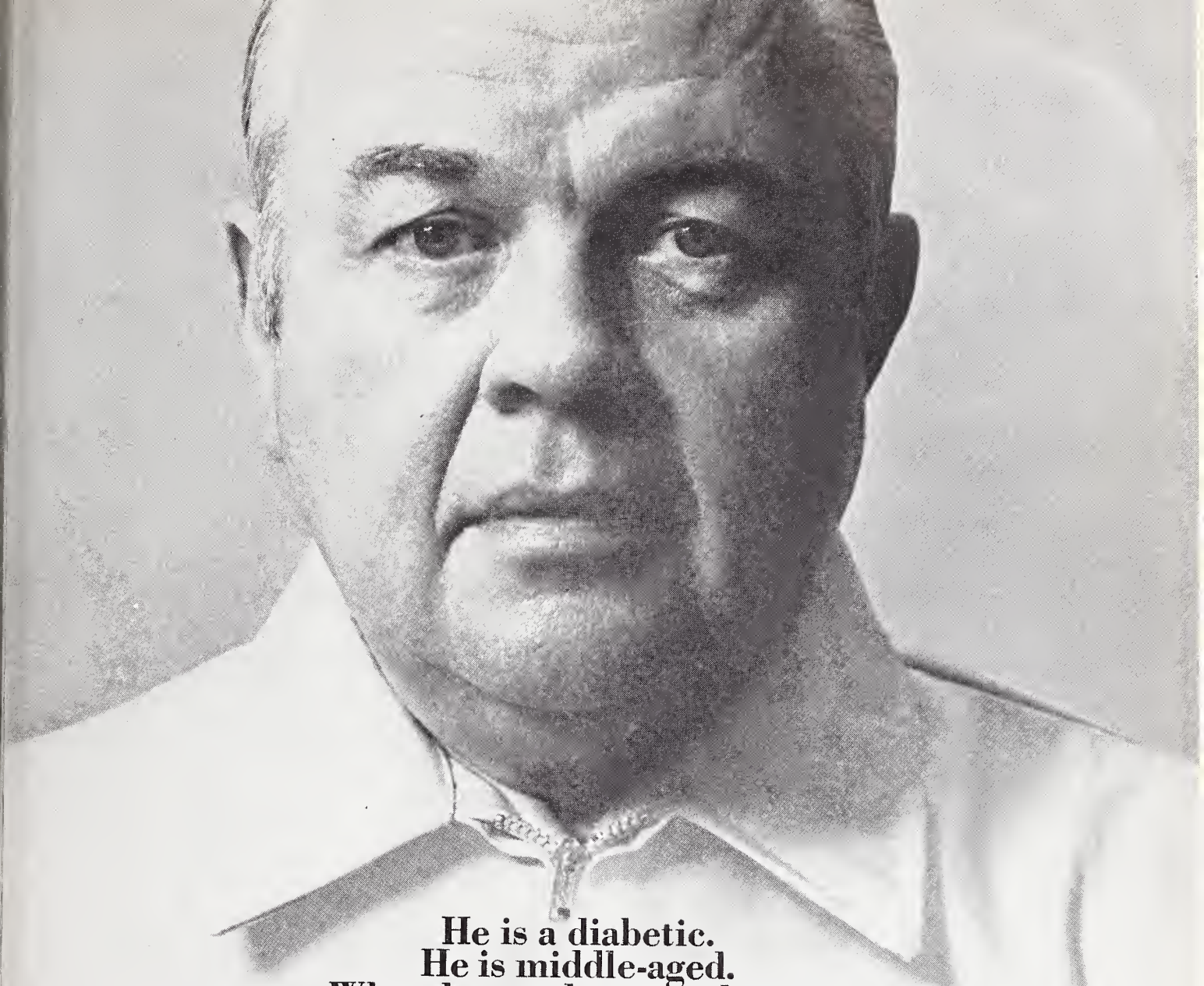
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Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

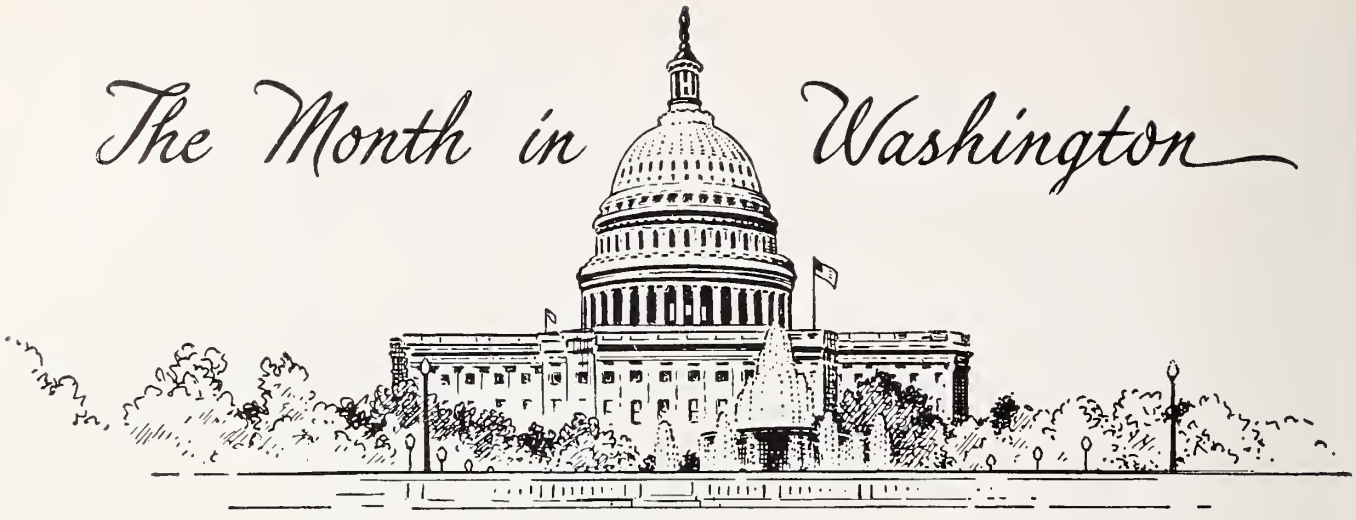
Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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The Month in Washington



Washington—The Nixon Administration called for limitations on Medicare and Medicaid reimbursements to physicians and hospitals.

Health, Education and Welfare Under Secretary John G. Veneman told the Senate Finance Committee that, because of rising costs, "it is now time to make some fundamental changes in the law which governs Medicare and Medicaid reimbursements." He said the reasonable cost and reasonable charge criteria in the Medicare law have not provided opportunity for major cost-control efforts.

"We need an incentive system of institutional reimbursement and we need changes in the law that will help control the increases in the amount that the Medicare program will recognize in the charges of individual practitioners. . . .

"I believe . . . that the law should be changed so as to limit further the rate at which increases in physicians' fees would be recognized by Medicare. The basic difficulty at present is that despite the improvements which have been made in applying reasonable charge guidelines, the best that can be done under present law is to introduce a lag in the recognition of fee increases. . . .

"Customary and prevailing charges under the program and the fees recognized by the carriers under comparable circumstances in their own business reflect, in the long run and after a suitable lag in recognition of fee increases, whatever physicians choose to charge the public generally in a market where growing demand is pressing increasingly on the limited supply of health personnel.

"Reliance on Blue Shield fee schedules as the limiting factor in Medicare reimbursement, as suggested in the Senate Finance Committee staff report, however, would not seem to us to have long-run viability. Tying payments under a program as large as Medicare to Blue Shield schedules would surely exert a major upward pressure on those schedules. . . .

"We believe that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to an index.

"Under such an approach, allowable charges recognized for Medicare would next year be generally limited to either presently recognized charges or to a new prevailing level set at the 75th percentile of 1969 average customary charges for a given service in an area. In the future the prevailing charge screen would move upward only in proportion to increases in an index made up of pertinent portions of wage and price indices. Under such an approach, recognition of fee increases would continue, but only in relation to things that are happening in other parts of the economy and that have a bearing on the physician's cost of doing business."

The American Medical Association said that any proposal for further limitations on physicians' fees under the government programs would be unwise.

"For all practical purposes, a freeze on physicians' fees under the two federal programs has been in effect for more than a year and has proven to be ineffective," Gerald D. Dorman, M.D., AMA President, said. "The costs of the program have continued to rise in spite of the freeze. Physicians are disturbed by threats of additional federal controls. Burdening these busy doctors with more red tape and restricting payments to unrealistically low levels may drive them away from participating in Medicare and Medicaid. Then the government will have discriminated against many people who need medical care. . . .

"The national interests would be better served if everyone joined with the American Medical Association in its efforts to provide more physicians."

* * *

The National Society for Medical Research said no valid finding on the effects of marijuana can be expected for another two to seven years.

Science Research Society said part of the difficulty is there is no standard yardstick for evaluat-

(Continued on page 232)



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



ing marijuana in scientific studies. The basic weed from which marijuana is made can vary from plant to plant and from country to country, the group said.

The federal government has negotiated new agreements with France and Turkey aimed at stemming the flow of heroin into this country.

But, in announcing the agreements, John E. Ingersoll, director of the Bureau of Narcotics and Dangerous Drugs, said the government's long-range objective in dealing with the problem is "to induce the medical community to find adequate substitutes" for opium, from which heroin is derived.

Ingersoll admitted the U. S. was asking a great deal of Turkey where opium has been grown for centuries.

"But when you've got over 900 deaths last year from heroin, 224 of them teenagers, in one city, I think you've got a right to start hollering," he said. "There have been three deaths a day from heroin in New York City this year. It is the major cause of death for 18 to 35-year-olds in New York City."

Ingersoll estimated 80 per cent of the 2.5 to 3 tons of heroin smuggled into the U. S. annually comes from Turkey poppy fields via the clandestine laboratories of France where the opium is refined into heroin.

The agreement with Turkey includes a $3 million loan approved by the agency for international development in 1968. The money is to be used partly to help the Turks substitute crops like sugar beets and sorghum for opium and partly to equip and train a 460-man narcotics police force.

The U. S. agreement with France calls for frequent meetings in Washington, D. C. and in Paris to exchange information on known drug traffickers, trafficking routes, etc. France also has assigned a force of 300 police to fight narcotics internally and 30 police to combat it at the international level. Ingersoll's narcotics bureau will increase its manpower in France next year and also will engage in a crosstraining program with French police.

* * *

Congress finally approved an appropriation bill acceptable to President Nixon to provide funds for the Health, Education and Welfare and the Labor departments for the 1970 fiscal year which began last July 1.

The two departments operated under stopgap Congressional resolutions while Nixon and Congress battled over how much money the bill should provide. The President vetoed the first bill passed by Congress on the ground that it would be inflationary because it exceeded his budget by $1.2 billion. Congress sustained the veto but still refused to go all the way with Nixon in cutting funds for the two departments. The second bill totaled $19.4 billion, $680 million more than the President requested. But Nixon accepted the compromise amount when Congress added a provision authorizing him to withhold two per cent of the funds.

The second bill had $176 million in Hill-Burton hospital funds, compared with $258 million in the vetoed measure. The appropriation for health facilities, educational research and libraries was cut from $149 million to $126 million.

Health manpower direct loan funds remained the same, $234.5 million, but an administration spokesman said it was planned to withhold $15.5 million. Other announced plans to withhold funds in the health field included:

—$6 million from $108.8 million for air pollution control;

—$6.3 million from $35.5 million for construction of community mental health centers;

—$6.3 million from $360.3 million for mental health programs;

—$8.7 million from $146.3 million for the National Institute of Arthritis and Metabolic Diseases;

—$5.7 million from $107 million for the National Institute of Neurological Diseases and Stroke;

—$1.3 million from $103.7 million for the National Institute of Allergies and Infectious Diseases;

—$10.3 million from $164.6 million for the National Institute of General Medical Sciences;

—$7 million from $76.6 million for general research and services.

* * *

The Food and Drug Administration announced plans to require that a warning leaflet be included in every package of birth control pills.

"I have come to the conclusion that the information being supplied to the patients in the case of the oral contraceptive is insufficient and that re-evaluation of our present policies is in order," FDA Commissioner Charles C. Edwards, M.D., told the Senate Monopoly Subcommittee at one of its public hearings on side-effects of birth control pills.

A proposed draft of the warning leaflet states that "there is a definite association between blood-clotting disorders and the use of oral contraceptive."

It emphasizes the importance of reporting any side-effects to "your doctor."

"All of the oral contraceptive pills are highly effective for preventing pregnancy, when taken according to the approved directions," the proposed draft says. "Your doctor has taken your medical history and has given you a careful physical examination. He has discussed with you the risks of oral contraceptives and has decided that you can take this drug safely.

"This leaflet is your reminder of what your doctor has told you. Keep it handy and talk to him if you are experiencing any of the conditions you find described. . . .

An American Medical Association spokesman questioned the tone of the language of the FDA's draft of the leaflet.

"In general, it is a good idea to have a package insert but the text of the FDA proposal raises serious question about the relationship between doctor and patient," he said. "It puts the full responsibility on the physician, but oral contraceptives generally are prescribed more as a convenience to a patient than as a medication. The patient must share responsibility both morally and legally and be alerted to her own responsibility."

The FDA now requires that pharmaceutical manufacturers only warn physicians and pharmacists of side-effects and possible hazards of taking birth control pills. Makers of the drugs were given opportunity to comment on the proposed leaflet after its publication in the FEDERAL REGISTER.

Identical bills designed to increase the number of physicians and allied health personnel in family medicine have been introduced in the House and Senate. Sponsors of the legislation say that prospects are good for Congressional approval this year.

The legislation would authorize $50 million for the current fiscal year of 1971, $75 million for fiscal 1972 and $100 million for each of the next fiscal years for grants to medical schools and hospitals. The grants would be to help medical schools and hospitals establish departments and programs in family practice of medicine and to encourage the training of allied health personnel in that field of medicine.

Sen. Ralph W. Yarborough (D.-Tex.) sponsored the legislation (S. 3418) in the Senate. Rep. Fred B. Rooney (D.-Pa.) introduced the bill (H.R. 15793) in the House first this year.

In the Wisdom of Congress

Following is a condensation of an editorial which appeared in the February 9, 1970 issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

When the Medicare legislation was adopted by the Congress in 1965, there was inherent in the legislation the requirement that the health services provided should be quality services. . . .

The Congress then and since has wisely excluded chiropractic and other such cults from services covered under the legislation.

The American Medical Association . . . believes that it shares with the Congress the responsibility of maintaining quality health care for the nation's elderly. To do otherwise—to include chiropractic—would reduce the quality and increase the cost of the program. . .

The Congress . . . in 1967 . . . requested . . . "a study relating to the inclusion under the supplementary medical insurance program . . . of services of additional types of licensed practitioners performing health services in independent practice."

That independent, unbiased study . . . (recommended) . . . "that chiropractic service not be covered in the Medicare program." The report fully documents the objectivity of the study, including extensive written evidence submitted by chiropractic and extensive oral testimony by chiropractic's foremost spokesmen, educators and practitioners.

The National Council of Senior Citizens, the nation's largest organization of Medicare recipients, consistently has supported the exclusion of chiropractic, most recently . . . when its president, Nelson H. Cruikshank, stated that inclusion of chiropractic "would represent another serious health hazard."

Numerous other organizations . . . have strongly supported the findings on chiropractic of the HEW study. Included, for example, are the AFL-CIO and the International Union, United Automobile, Aerospace and Agricultural Workers of America (UAW).

Among the many other organizations which . . . have supported the HEW findings on chiropractic are the American Osteopathic Association and the American Public Health Association. . . .

Additionally, an independent task force appointed to study Medicaid and related programs reported to the Secretary of HEW . . . its opposition to chiropractic and naturopathic inclusion under Medicare and also recommended that "a legislative amendment should be enacted denying federal financial participation in Medicaid payments to chiropractic and naturopaths."

The AMA believes such unscientific cult practices as chiropractic and naturopathy have a prime obligation before they can be considered for inclusion in such universal health-care programs as Medicare: They must prove, as all in the scientific field must prove, that there is scientific validity for the basic concepts on which their services are based. In this era of scientific advancement, there must never be established a double standard of health care for the people—one scientific and one cultist.

COMING MEETINGS

IN STATE

Apr. 2-3 **Fourteenth Annual Raymond Blank Hospital Pediatric Conference,** Iowa Methodist School of Nursing Auditorium, Des Moines.

Apr. 3-4 **Eighth Annual Orthopaedic and Rehabilitation Seminar,** Younkers Rehabilitation Center, Des Moines.

Apr. 26-29 **Annual Meeting, Iowa Medical Society,** Fort Des Moines Hotel, Des Moines.

May 8 **Conference on Battered Child Syndrome, University of Iowa College of Medicine,** Iowa City.

CONTINENTAL U. S.

Apr. 1. **First Alcoholism Medical Education Conference, sponsored by National Council on Alcoholism,** 2 Park Avenue, New York City.

Apr. 1-2 **Postgraduate Course on Advances in Infectious Disease,** Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

Apr. 2-3 **Practicing Physician and Endocrine Metabolic Disorders in Children sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Apr. 2-5 **Missouri State Medical Association,** Muehlebach Hotel, Kansas City.

Apr. 3-4 **American Geriatrics Society,** Americana Hotel, New York.

Apr. 6-7 **Postgraduate Course on Sports Medicine,** Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio.

Apr. 6-8 **American Association for Thoracic Surgery,** Washington-Hilton Hotel, Washington, D. C.

Apr. 6-8 **Postgraduate Course in Ophthalmology,** Kansas University Medical Center, Kansas City, Kansas.

Apr. 6-10 **Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta, Georgia.

Apr. 6-10 **Postgraduate Course on High Risk Infant Care (Limited) sponsored by University of Colorado School of Medicine,** Denver.

Apr. 6-17 **Postgraduate Course in Laryngology and Bronchoesophagology sponsored by University of Illinois Medical Center,** Chicago.

Apr. 9-10 **Dreams and Reality in Maternal Child Nursing,** U. of Kansas Medical Center, Kansas City.

Apr. 9-10 **23rd National Conference on Rural Health,** Pfister Hotel and Tower, Milwaukee.

Apr. 9-11 **Tennessee Medical Association,** Sheraton-Peabody Hotel, Memphis.

Apr. 9-11 **Current Concepts in Physiology of the Gastrointestinal, Endocrine and Respiratory Systems sponsored by American College of Physicians and American Physiological Society,** Holiday Inn, Philadelphia.

Apr. 10 **Postgraduate Course on Pediatric Neurology sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Apr. 10-12 **American Society of Internal Medicine,** Warwick Hotel, Philadelphia.

Apr. 12-16 **American Proctologic Society,** The Diplomat, Hollywood, Florida.

Apr. 12-17 **American College of Physicians,** Bellevue Stratford Hotel, Philadelphia.

Apr. 12-17 **American Physiological Society,** Holiday Inn, Atlantic City.

Apr. 12-18 **American College of Obstetricians and Gynecologists,** Americana Hotel, New York.

Apr. 13-15 **American Academy of Pediatrics,** Washington-Hilton, Washington, D. C.

Apr. 13-15 **Postgraduate Course in Anesthesiology,** Kansas University Medical Center, Kansas City, Kansas.

Apr. 13-16 **American Industrial Health Conference sponsored by Industrial Medical Association and American Association of Industrial Nurses,** Palmer House, Chicago.

Apr. 13-17 **American Association of Immunologists,** Atlantic City.

Apr. 15-17 **Postgraduate Course on Management and Care of Respiratory Insufficiency sponsored by University of Colorado School of Medicine,** Denver.

Apr. 16-18 **Indiana Chapter, American College of Surgeons,** Indiana State University, Terre Haute.

Apr. 16-18 **The Pulse of Laboratory Medicine sponsored by University of Florida College of Medicine, Pinellas County Medical Society and Florida Academy of General Practice,** Tides Hotel and Bath Club, Redington Beach, Florida.

Apr. 17 **Postgraduate Course on Infectious Diseases,** Kansas University Medical Center, Kansas City, Kansas.

Apr. 19-20 **American Otological Society,** Hollywood Beach Hotel, Hollywood, Florida.

Apr. 19-23 **American Association of Neurological Surgeons,** Shoreham Hotel, Washington, D. C.

Apr. 20-23 **Southwestern Surgical Congress,** Sheraton-Dallas Hotel, Dallas.

Apr. 21-25 **Arizona Medical Association,** Marriott's Camelback Inn, Scottsdale.

Apr. 22-23 **Postgraduate Course in Pathology,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.

Apr. 22-24 **Second Annual Symposium on Chronic Respiratory Diseases sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

Apr. 23-25 **Annual Meeting Mid-Central State Orthopaedic Society,** Skirvin Hotel, Oklahoma City.

Apr. 23-25 **Postgraduate Course on Recent Advances in Endocrinology and Selected Metabolic Diseases sponsored by American College of Physicians,** University of California Medical Center, San Francisco.

Apr. 26-29 **Arkansas Medical Society,** Arlington Hotel, Hot Springs.

Apr. 27-29 **American Surgical Association,** The Greenbrier, White Sulphur Springs, West Virginia.

Apr. 27-30 **Nebraska State Medical Association,** Hotel Cornhusker, Lincoln.

Apr. 27-May 2 **American Academy of Neurology,** Americana Hotel, Miami Beach.

Apr. 29-May 2 **American Pediatric Society,** Traymore Hotel, Atlantic City.

Apr. 30-May 3 **Texas Medical Association,** Dallas.

May 3-6 **Kansas Medical Society,** Wichita.

May 3-9 **Hawaii Medical Association,** Hilton Hawaiian Village, Honolulu.

May 4-5 **Congress on Environmental Health,** Statler Hilton Hotel, Washington, D. C.

May 4-29 **Postgraduate Course on Medical Radioisotopes sponsored by Special Training Division of Oak Ridge Associated Universities,** Oak Ridge, Tennessee.

May 4-29 **Postgraduate Course on Nuclear Medical Technology sponsored by Special Training Division of Oak Ridge Associated Universities,** Oak Ridge, Tennessee.

(Continued on page 242)

ou are considering weight reduction, consider

Preludin®
phenmetrazine hydrochloride
Endurets®
prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

Long acting

Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

Once-a-day dosage

One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by mid-morning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.

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Greetings from the Office of the Dean

Dear Members and Friends of the Iowa Medical Society:

On September 1, 1969, Robert C. Hardin, M.D., became Vice-President for Health Affairs at the University of Iowa and vacated the Deanship in the College of Medicine. During the interim in which a regular successor is being sought, I have been appointed to manage the affairs of the College, and I am pleased to extend to each of you the warmest greetings of the Faculty and Staff of the College of Medicine. Partly because of our search for a permanent Dean, partly because of drawing more heavily on the talents of some of you in our programs of instruction, and partly because of new developments related to family practice, we have enjoyed particularly close and effective relationships with members of the Iowa Medical Society during the past year.



Of major significance is the fact that on January 15, 1970, the State Board of Regents approved the College's request to create a new academic department, the Department of Family Practice. This department will have its main offices in Iowa City and will develop and coordinate undergraduate educational and postgraduate training programs in family medicine. As a department with equal administrative status to all other departments in our College, it will also have a research mission. It is especially appropriate that this mission should include studies on methods for the delivery of health care in our state. Surveys of our students indicate between one-quarter and one-third of them would be interested in family practice provided high-quality, first-line training programs could be developed. Moreover, the College's administrators and faculty overwhelmingly supported the recommendation to establish a new department. By the time these words are published, recruitment for the Head of the new department should be well underway. This person, like the faculty he will attract, will be selected from among individuals who have had extensive experience in the practice of general medicine. The College is excited and optimistic about this new venture, and hopes through it to help meet the health needs of our state and nation.

1970 is the Centennial Year for the College of Medicine and a good many commemorative activities are planned. A Centennial Committee of faculty and physicians in the state is chaired by Dr. Jack Moyers. You will hear about Centennial activities all through the year, but a major thrust is planned for mid-September with the admission of the freshman class that marks the beginning of our second 100 years. You may wish to reserve some time during the week of September 14-19 to visit the College and participate in the activities of which you will soon be notified.

The College has implemented a new, flexible and forward-looking curriculum during this past year. In addition, we plan to increase enrollment in both freshmen and junior classes in the fall of 1970 such that our total student body should be augmented by 20 to 25 per cent.

We are encouraged by these developments and especially by the continuing support we have enjoyed from physicians in the state. We intend to work to draw the Iowa Medical Society and the College even more closely together as we labor to meet the health needs of our citizens.

Sincerely yours,

William O. Rieke, M.D.
Dean pro tem

The University of Iowa College of Medicine: 100 Years Ago

WILLIAM B. BEAN, M.D.
Iowa City

OUR CULTURE IS FASCINATED by the decimal system. The passage of 100 years effectively removes all the witnesses, allowing those currently on the scene to take stock and review the situation as it was in times gone by. Usually they claim great progress, bask in the glow of self-satisfaction, and await the plaudits of a multitude of those who come to express approval. But at least a centennial is a clear milestone in the course of history. The marker lets us reflect and make comparisons. Thoughtful men will remember that the passage of time and the movement of events and things are not necessarily the same as progress. So with a sense of respect for history, comingled with pride in the medical institution of the University of Iowa, we look back at our meager beginnings.

A hundred years ago, on September 20, 1870, a school of medicine opened at the University of Iowa. It has continued its career with no interruption but not without interesting periods of excitement and even turmoil. The first authentic example of medical education in Iowa was the preceptorship of a village school teacher, Berryman Jennings. Dr. Isaac Galland, who lived in Nashville, just north of Keokuk in 1829, allowed Jennings to read his medical books and gave Jennings meals and lodging in return for teaching the local children. This was a fairly common arrangement.

Proprietary schools were springing up all over the middle west by the 1850's. The first Iowa Medical school had an odd beginning. A charter for the establishment of the Rock Island Medical School was obtained in Wisconsin since it was easier to get a charter there than in Illinois. The school was chartered as the Rock Island Branch of the Madison Medical College, though Madison never had a college established under this charter. The school lasted only one year. Then its charter and functions went across the river to Davenport, lured by the availability of the first medical building in Iowa for teaching. There was actually a faculty and a curriculum. The requirements for graduation were three years of medical study, being 21 years of age and passing a final examination. Of course various fees were extracted. These went to the professors. The Davenport school also lasted only a year. Then the charter and certain equipment went to the College of Physicians and Surgeons of Keokuk. For a time this was the Medical Department of the State University. It lasted from 1850 to 1899 when Keokuk turned over its equipment to Drake.

This was not all the medical schools, for there was a Council Bluffs Medical College from 1893 to 1895; a Sioux City College of Medicine from 1890 to 1908; and in Des Moines there was an Iowa eclectic Medical College at Drake from 1881 to 1887; the King eclectic Medical College endured from 1883 to 1889; and the Iowa College of Physicians and Surgeons from 1882 to 1886, when it merged with the Medical Department at Drake University, continuing from 1886 to 1913.

The story of the founding of the College of Medicine of the University of Iowa and its establishment in 1870 is characteristic of the turbulence of the times. A multitude of forces tugging many ways prevailed throughout the country in the period after the Civil War. Just the year before, in 1869, the spanning of the continent by the joining of two railroad systems had been completed; and the Colorado River had been explored by Powell. Indians

and buffalo still occupied large parts of the open west. The sciences of microbiology and chemistry were just beginning to have effects. Medicine was slowly beginning to come out of the doldrums with the emergence of Lister's antisepsis to make safe the host of operations anesthesia had made painless.

The College of Physicians and Surgeons at Keokuk was, by act of the legislature in 1850-1851, affiliated with the University. This is the way things stayed until the year 1868, when an ambitious young doctor, W. F. Peck of Davenport, supported by Judge Dillon, whom he had successfully nursed through a severe attack of typhoid fever, and the Honorable John P. Irish, editor of an Iowa City newspaper and member of the Iowa legislature, worked up a complete outline for organizing a medical department. They presented it to the Board of Trustees of the University of Iowa on September 17, 1868. The committee reported to the Board the following unanimously adopted resolution: "That there be and is hereby established a medical department in the University with the following chairs: surgery, anatomy, materia medica, obstetrics, physiology, microscopic anatomy, principles and practice of medicine, and chemistry." Fees and tuition were to go to the Medical Department as the medical school was then called. Professors were to serve without compensation until the trustees or the legislature could find money to pay them.

The governance of the Department was vested in the faculty. Appointments were to be approved by the Board of Trustees and annual reports on the "acts and condition of the department" were to be made to the trustees. In June, 1868, money was made available to remodel the rooms in South Hall for the needs of the Medical Department, including an amphitheater and laboratories, and a basement with a dissecting room. The trustees at the same time provided that a faculty should be selected not later than the fall of 1870. Shortly, bitter opposition arose, chiefly from Keokuk and its fairly large body of medical alumni. After an acrimonious session, the State Medical Society presented to the Governor and the General Assembly a series of strongly opposing resolutions. A bill to abolish the Medical Department was passed by the Senate but failed in the House. So the original proposal held. A new Board of Regents was obtained and the first faculty selected. It consisted of:

Dr. W. F. Peck of Davenport, Surgery

Dr. W. S. Robertson of Muscatine, Theory and Practice of Medicine

Dr. P. J. Farnsworth of Clinton, Materia Medica

Dr. W. D. Middleton of Davenport, Physiology and Microscopical Anatomy

Dr. J. T. H. Boucher of Iowa City, Anatomy

Dr. J. F. Kennedy of Tipton, Obstetrics

Dr. J. C. Shrader of Iowa City, Gynecology

Professor Gustavus Hinrichs of Iowa City, Chemistry

Hon. Jno. F. Dillon of Davenport, Medical Jurisprudence

Dr. Kennedy turned down his appointment so Shrader took on obstetrics as well as gynecology, a situation which still prevails.

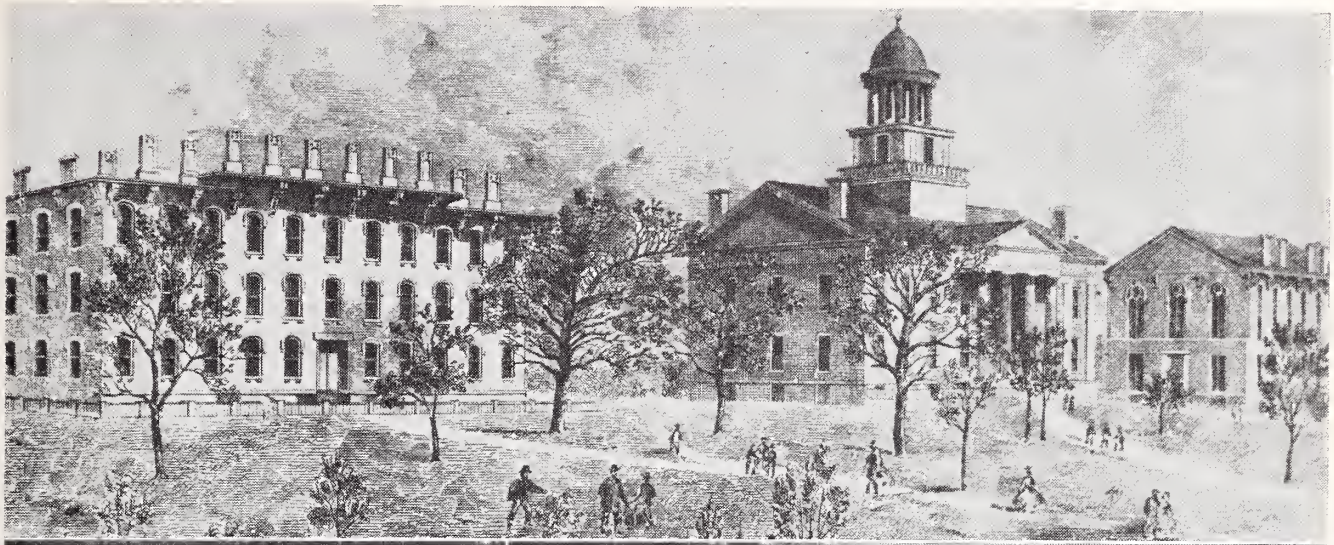
The faculty was indeed peripatetic and the roads from Davenport, Muscatine, and Clinton were kept busy. Those who lived away had to pay their own travel expenses, and they got no salary. As with any new school, the reputation was that of its professional staff. School opened on September 20, 1870, with a two-week introductory brushing up period. This was followed by the regular medical course which extended over 16 weeks. This was about average for the country at the time.

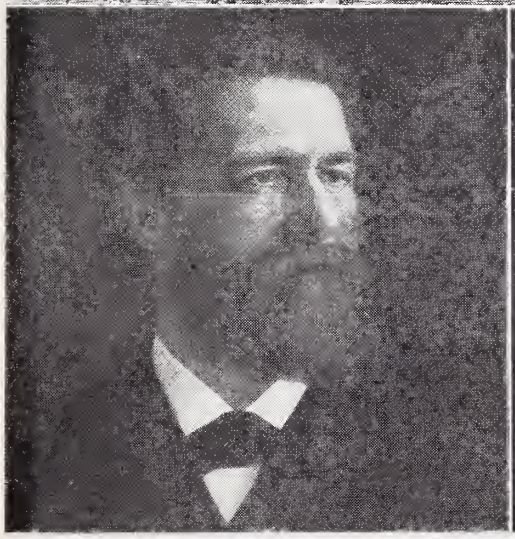
Iowa was unique in beginning as a coeducational school, there being 10 women in a class totaling 37. In the Victorian Period, this mingling of the sexes seemed promiscuous, to say the least. A storm of protest arose both locally and throughout the country. It had been established wisely as a basic principle of the University of Iowa at its founding that all facilities were to be available to men and women alike. The faculty resisted to no avail.

Admission requirements were simple. There

IOWA MEDICAL EDUCATION: CIRCA 1870

These illustrations depict the early days of the College of Medicine. The upper lithograph shows the Old Capitol and the Pentacrest. The middle left is a painting of Washington Freeman Peck, first Dean of the College of Medicine. Middle right photo shows the original faculty: Standing—Hinrichs, Shrader, Robertson, Middleton and Clapp; Seated—Farnsworth, Peck and Dillon. The lower chart reveals a "lecture stuffed curriculum." ⟶







PROGRAMME OF LECTURES

IN THE MEDICAL DEPARTMENT,

IOWA STATE UNIVERSITY—SESSION 1870-71.

Time.	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
9 A. M.,	Boucher.	Boucher.	Shrader.	Boucher.	Boucher	
10 A. M.,	Farnsworth.	Farnsworth.	Farnsworth.	Farnsworth.	Farnsworth.	Farnsworth.
11 A. M.,	Robertson.	Peck.	Middleton.	Robertson.	Peck.	Smith.
1 P. M,	Medical Clinic.	Hinrichs.	Eye and Ear Clinic.	Hinrichs.	Surgical Clinic.	
2 P. M.,	Shrader.	Shrader.	Hazen.	Shrader.	Hinrichs.	
3 P. M.,	Middleton.	Peck.	Middleton	Robertson.	Hinrichs.	

were none. There was complete integration of the preclinical and clinical subjects. The student beginning and the student about to graduate took exactly the same course. Clinics were held in Old South Hall. To graduate one had to pay $25 for a diploma; have "an unexceptionable moral character"; have been engaged in the study of medicine for three years and had to have taken the course at the college for two years. Not only was he required to present an acceptable written thesis but had to pass a satisfactory examination on all the subjects. All 37 applied for graduation, but only Isaac Potter, Nathan Collis and Homer Page received the degree in commencement exercises held March 21, 1871.

The first year of school was marked by one exciting episode. A body in the local cemetery disappeared from a fresh grave. Even though the medical building was searched and no body found, the public was convinced that the medical school was to blame. A night or so later the body mysteriously reappeared in a new wooden coffin outside the back door of the local mortuary. Near the vacant grave a notebook was found which belonged to Dominick Bradley, the medical building janitor and coachman for Dr. Boucher, professor of anatomy. The alert doctor and his coachman promptly disappeared from Iowa City. Dr. Clapp, an Iowa City physician, was appointed to take the chair of anatomy; Billy Green became janitor. It was three years before the University had its first hospital.

Thus, 100 years ago our College of Medicine opened formally. It had the outstanding distinction of being the first coeducational medical school anywhere in modern times. It survived an episode of grave robbing and it managed as a self-sustaining operation through the devotion of and concern of physicians who served without fee or favor out of a sense of loyalty as well as for whatever reputation might be associated with the job. From these small beginnings, 100 years ago, has evolved the great modern medical center at Iowa City.

College of Medicine Admission Requirements

Collegiate advisors over the state have advised the Admissions Committee of the University of Iowa College of Medicine that many of their premed students are misinformed about requirements for admission to the College of Medicine.

Current requirements for admission to the College of Medicine provide that the applicant must have: 1) received the baccalaureate degree; or 2) completed three years of a combined baccalaureate-medicine curriculum, qualifying the student to receive the baccalaureate degree on completion of the first year in medicine; or 3) completed three years of a baccalaureate program, this program to include those general graduation requirements needed in the College of Liberal Arts of the University of Iowa to earn the combined baccalaureate degree.

The applicant should have attained a grade point average of at least 2.5 for all college work undertaken (based on a schedule of A = 4.0). The specific subject area requirements, with appropriate laboratory experience, include:

1. *Physics:* A complete introductory course.

2. *Mathematics:* College algebra and trigonometry, or one course of more advanced college mathematics when college algebra and trigonometry were completed in high school.

3. *Chemistry:* The chemistry background should include (1) a complete introductory course in modern general chemical principles, and (2) a complete introductory course in organic chemistry.

4. *Biological Sciences:* This requirement may be satisfied by a complete introductory course in the principles of animal biology or zoology and botany (but not botany alone); plus one advanced course in biology.

Aspiring medical students must have college work other than the prerequisite sciences. In the interests of securing a well-rounded education, which is important to those entering the medical profession, students are urged to take courses in as much depth as possible in the following categories: literature, history, psychology, economics, philosophy, mathematics, sociology, fine arts and foreign languages.

Each applicant must take the Medical College Admissions Test, which is administered in the spring and fall of each year at several locations throughout the state. Preference is given to those applicants with high scholastic standing who are residents of Iowa. Interested students should be urged to obtain current and additional information from the Office of the Registrar at the University of Iowa.

College of Medicine Recognizes Preceptors

Since 1954 the University of Iowa College of Medicine has included in its curriculum a mandatory preceptorship. Each medical student has spent four weeks in the office of a private practitioner. This experience was felt to be an important, integral aspect of the student's total learning experience.

The program was originally conceived to produce more general practitioners for Iowa. It apparently succeeded better in teaching the students about the practice of office medicine, and the relationships between practitioners and their colleagues, patients, office employees and the communities in which they work. Specific problems relating to diagnosis and therapy, and other aspects of medical practice, such as office efficiency and bookkeeping, are exposed to the student during the preceptorship in a manner which cannot be duplicated in the academic medical center. In the preceptorship, the student must face the need to be realistic in his choice of diagnostic and therapeutic maneuvers. It is here more than anywhere else in his formal medical education that he discovers "common diseases occur commonly and rare diseases rarely."

The comments and reports filed by the students about their preceptorships have been remarkably enthusiastic. And even though many of the students stated honestly that the experience did not persuade them to enter general practice, they nonetheless felt it was a valuable experience.

In more recent years the College has permitted students to elect a preceptorship with an Iowa practitioner regardless of his medical specialty. The Preceptorship Committee, however, has preferred the experience be in a practice that delivers continuing and comprehensive health care, as much as possible. Occasionally students are given permission, because of their special circumstances, to take a preceptorship outside of Iowa or in a somewhat different way.

The College is grateful to the many Iowa practitioners who have served the medical students in this way. Listed here are those Iowa physicians who have served the College as preceptors during 1968-69.

Robert W. Anderson, M.D., Des Moines
Robert W. Asthalter, M.D., Muscatine
William A. Baird, M.D., Ames
Arthur E. Barnes, M.D., Cedar Rapids
Marian L. Barnes, M.D., Cedar Rapids
James G. Bauman, M.D., Charles City
W. C. Baumann, M.D., Fairfield
Thaddeus T. Bozek, M.D., Iowa City
Alfred Brendel, M.D., Central City
Ivan E. Brown, M.D., Hartley
Paul F. Brown, M.D., Maquoketa
Burns M. Byram, M.D., Marengo
Rodney R. Carlson, M.D., Ankeny
James H. Coddington, M.D., Humboldt
Kenneth R. Cross, M.D., Iowa City
Victor G. Edwards, M.D., Iowa City
Charles R. Eicher, M.D., Iowa City
Craig D. Ellyson, M.D., Waterloo
Maurice Estes, M.D., Cedar Rapids
Donald K. Faber, M.D., LeMars
Allan G. Felter, M.D., Van Meter
Robert K. Fryzek, M.D., Glenwood
Webster B. Gelman, M.D., Iowa City
Lawrence R. Gray, M.D., Ankeny
Don C. Green, M.D., Des Moines
Dale A. Harding, M.D., Eagle Grove
Gerald W. Howe, M.D., Iowa City
Lewis H. Jacques, M.D., Iowa City
Kenneth Judiesch, M.D., Iowa City
John F. Kanealy, M.D., Cedar Rapids
Stewart F. Kanis, M.D., Pella
Karl Larsen, M.D., Iowa City
Lawrence V. Larsen, M.D., Harlan
Scott Linge, M.D., Fayette
John K. MacGregor, M.D., Mason City
John R. Maxwell, M.D., Iowa City
Earl J. McKeever, M.D., Knoxville
Murry L. McCreedy, M.D., Washington
Donald F. Miller, M.D., Williamsburg
Jay R. Miller, M.D., Wellman
Lawrence A. Miller, M.D., North English
Caryle C. Moore, M.D., Emmetsburg
Thomas W. Murphy, M.D., Cedar Rapids
Thomas R. Nicknish, M.D., Iowa City
Arnold T. Nielsen, M.D., Ankeny
H. Dudley Noble, M.D., Iowa City
John C. Peterson, M.D., Hartley
John L. Powers, M.D., Estherville
Aaron P. Randolph, M.D., Anamosa
Larry Rigler, M.D., Iowa City
Harry V. Robison, M.D., Sioux City
William Robson, Jr., M.D., Cedar Rapids
E. O. Schlichtemeier, M.D., Spencer
John M. Schutter, M.D., Algona
Charles A. Skaugstad, M.D., Coralville
Thomas E. Stark, M.D., Cedar Rapids
Richard G. Stuelke, M.D., West Branch
Robert L. Swaney, M.D., Cedar Rapids
Thomas F. Thornton, Jr., M.D., Waterloo
John K. Uchiyama, M.D., Des Moines
Gene K. VanZee, M.D., Pella
Ellis K. Vaubel, M.D., Estherville
Max T. Wainwright, M.D., Sioux City
David Wall, M.D., Ames
Desmond Waters, M.D., Williamsburg
Perry L. Weigel, M.D., Van Meter
Ralph L. Wicks, M.D., Boone
James G. Widmer, M.D., Wayland
Bernhard G. Wiltfang, M.D., Grinnell

Coming Meetings

(Continued from page 234)

May 6-7 **Postgraduate Course on Progress in Cardiovascular Disease**, Cleveland Clinic, 2020 East 93rd Street, Cleveland.

May 6-8 **American Association of Genitourinary Surgeons**, Cascades Hotel, Williamsburg, Virginia.

May 7-8 **Third National Conference on Voluntary Health Agencies**, Statler Hilton Hotel, Washington, D. C.

May 7-8 **Symposium on Progress in Diabetes and Insulin Research**, University of Nebraska Medical Center Campus, Omaha.

May 7-9 **American College of Sports Medicine**, Western Skies Hotel, Albuquerque.

May 7-10 **Florida Medical Association**, Diplomat Hotel, Hollywood-by-the-Sea, Florida.

May 10-14 **American Urological Association**, Bellevue-Stratford Hotel, Philadelphia.

May 9 **American College of Psychiatrists**, San Francisco.

May 10-13 **American Association of Plastic Surgeons**, Broadmoor Hotel, Colorado Springs.

May 11-12 **Postgraduate Course on New Concepts in Cardiac Arrhythmias**, Kansas University Medical Center, Kansas City, Kansas.

May 11-14 **State Medical Society of Wisconsin**, Sheraton-Schroeder Hotel, Milwaukee.

May 11-15 **American Psychiatric Association**, San Francisco.

May 13-16 **Postgraduate Course on Trauma sponsored by Chicago Committee on Trauma of American College of Surgeons**, John B. Murphy Auditorium, Chicago.

May 14-16 **Symposium on Cardiovascular Diseases**, Saint Francis Hospital, Hartford, Connecticut.

May 14-16 **National Conference on Breast Cancer**, Brown Palace Hotel, Denver.

May 14-16 **First Biennial Meeting of Western Conference on Criminal and Civil Problems**, Broadview Hotel, Wichita, Kansas.

May 15-16 **Surgery and 15th Annual Trauma Day sponsored by University of Nebraska Medical Center**, Campus of Medical Center, Omaha.

May 17-20 **Illinois State Medical Society**, Sherman House, Chicago.

May 18-20 **Minnesota State Medical Association**, Duluth.

May 20-23 **American Gastroenterological Association**, Sheraton-Boston, Boston.

May 20-22 **Postgraduate Course on Clinical Aspects of Infectious Diseases sponsored by American College of Physicians**, University of Washington School of Medicine, Seattle.

May 21-22 **Postgraduate Course on Advances in Dermatology**, Cleveland Clinic, 2020 East 93rd Street, Cleveland.

May 21-22 **Postgraduate Course on Cardiovascular Disease sponsored by University of Nebraska Medical Center**, Omaha.

May 21-23 **Postgraduate Course on Pediatric and Adolescent Psychiatry sponsored by University of Florida College of Medicine, Pinellas County Medical Society and Florida Academy of General Practice**, Tides Hotel and Bath Club, Redington Beach, Florida.

May 22-29 **10th International Cancer Congress**, Houston Civic Center, Houston.

May 24-27 **American Thoracic Society**, Sheraton Hotel, Cleveland.

May 25 **American Society of Clinical Oncology**, Houston.

May 25-27 **American Gynecological Society**, The Homestead, Hot Springs.

May 27-29 **Postgraduate Course on Heart Disease—Clinical and Pathological Correlation sponsored by American College of Physicians**, Georgetown University Hospital, Washington, D. C.

May 28-30 **American Ophthalmological Society**, The Homestead, Hot Springs.

ABROAD

Apr. 1-4 **German Surgical Society**, Munich.

Apr. 6-8 **European Congress of Perinatal Medicine**, London.

Apr. 9-11 **Biennial Meeting on Gynecology and Obstetrics**, Mexico City.

Apr. 11-17 **American Orthopaedic Association, Annual Meeting**, Melbourne, Australia.

Apr. 20-24 **17th Biennial Congress, International College of Surgeons**, Paris.

Apr. 26-30 **First International Congress on Group Medicine**, Winnipeg, Manitoba, Canada.

Apr. 30-May 1 **Irish Ophthalmological Society**, Dublin.

May 6-8 **Workshop-Type Symposium on Medical Intensive Care sponsored by American College of Physicians**, University of British Columbia, Vancouver, B. C., Canada.

May 8-13 **World Congress on Prevention of Occupational Accidents and Diseases (6th)**, Vienna.

May 10-14 **Annual Meeting, German Oto-Rhino-Laryngology Society**, Hamburg.

May 11-13 **European Society for Experimental Surgery, 5th Congress**, Venice, Italy.

May 30-June 1 **Pan American Cancer Cytology Congress (4th)**, Ocho Rios, Jamaica.

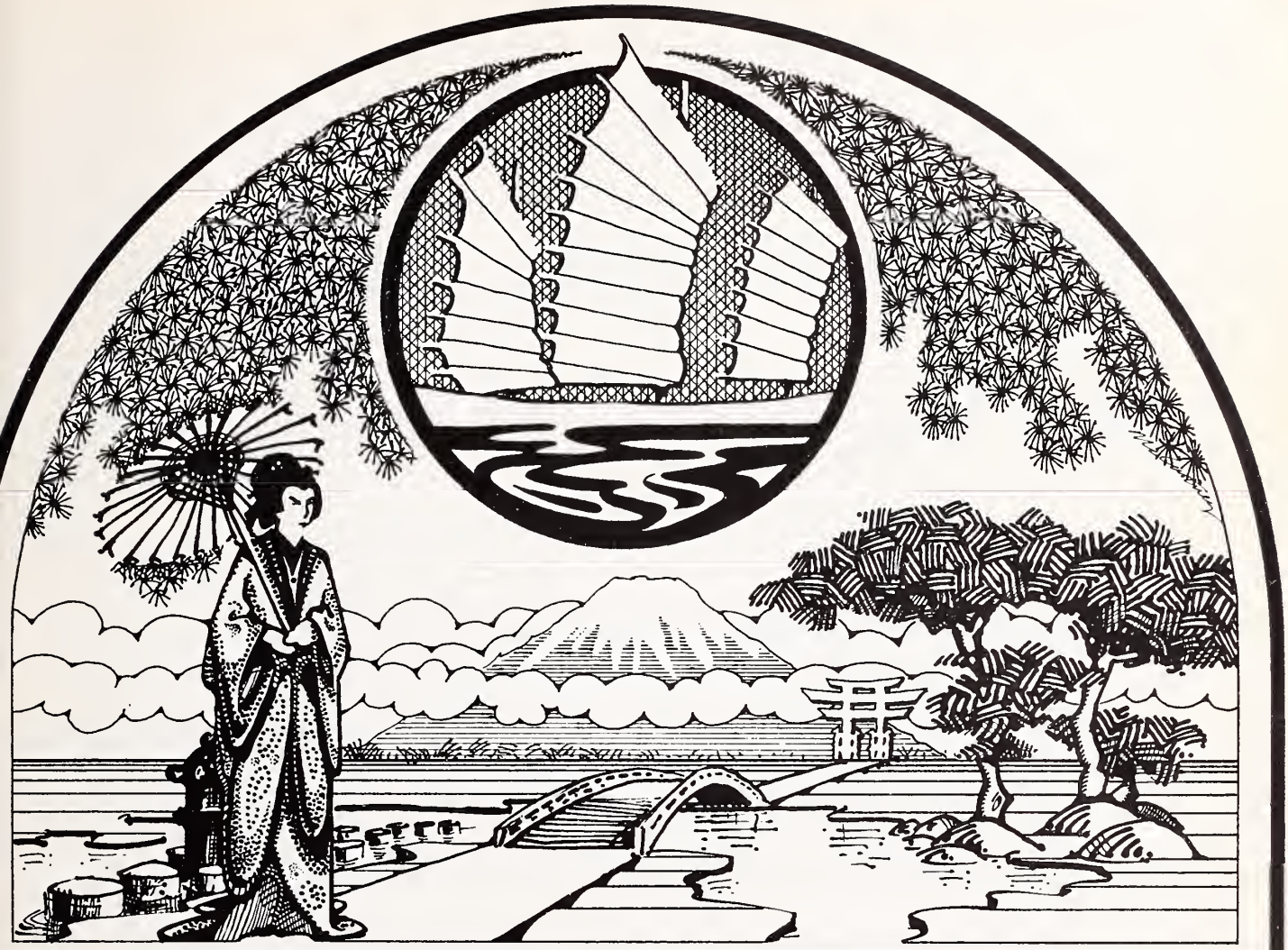
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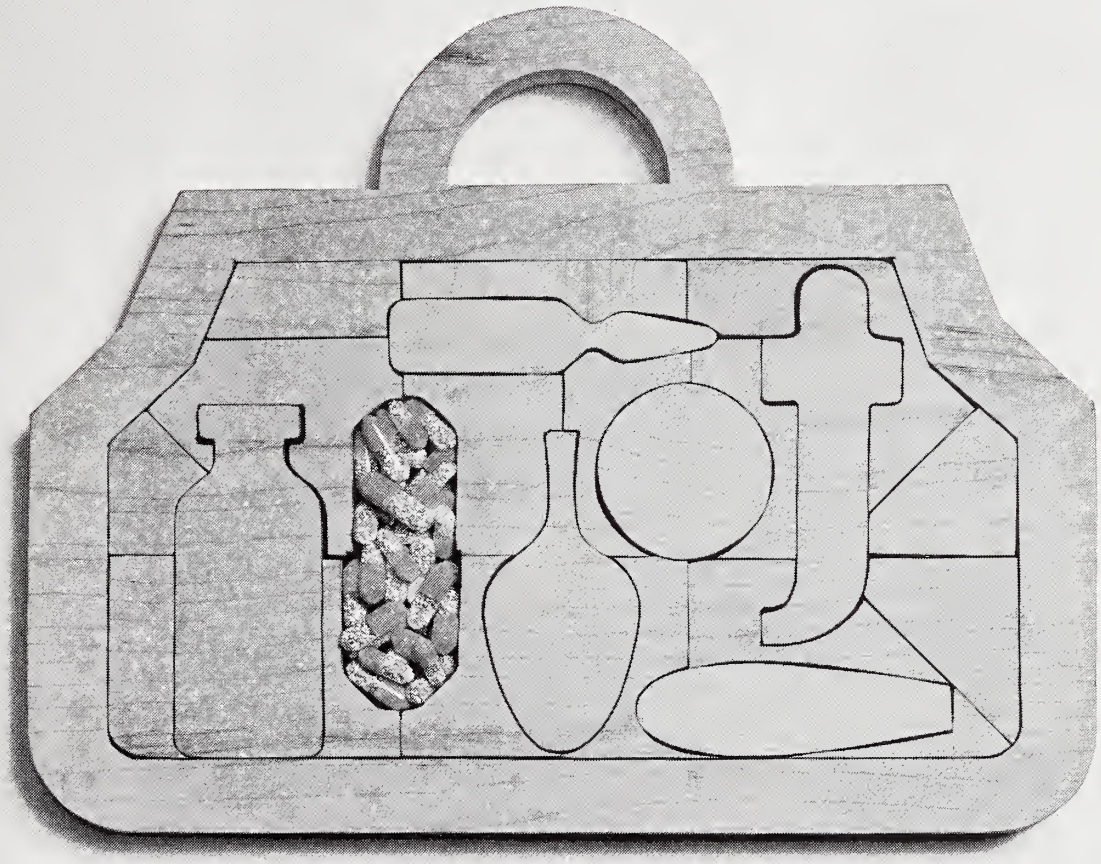
1970 ANNUAL MEETING IOWA MEDICAL SOCIETY

- *Monday, April 27: Clinical Problems Confronting the Physician*
- *Tuesday, April 28: Survival on Earth, in Space, Under Water*
- *Exhibits / Luncheon Sessions / President's Reception / Medical Alumni Reunion Annual Banquet / Specialty Group Dinners*

NOTE: Sunday, Monday, and Tuesday Sessions to be held at Hotel Fort Des Moines; Wednesday Session, Hotel Savery.

— APRIL 26 to 29 — DES MOINES, IOWA

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Scientific Articles

Kidney Transplantation in Iowa: A Progress Report

WILLIAM W. BONNEY, M.D.
Iowa City

In November 1969 the University of Iowa-Veterans Administration Hospital Transplantation Service began its program of human renal transplantation. Since that time three cases have been done. Two cases are far enough along to warrant review and will form the substance of this report.

This report is submitted on behalf of all the collaborating departments, including Medicine, General Surgery, Urology, Pediatrics, Radiology, Pathology and Laboratory Service, Anesthesiology, Social Service and the Nursing Service.

The Transplantation Committee members are Dr. Walter Kirkendall, Department of Medicine; Dr. Rubin Flocks, Department of Urology; and Dr. Sidney Ziffren, Department of General Surgery. Ex-officio members are Dr. Richard Eckhardt of the Veterans Administration Hospital and Mr. John Colloton of the University Hospital. This committee is appointed by the College of Medicine to support and stimulate all transplantation activities.

Dr. Bonney is an assistant professor of urology at the U. of I. College of Medicine. He is also chief, Urology Service, Veterans Administration Hospital, and coordinator, Kidney Transplant Team.

The Kidney Transplant Team (full-time staff members participating in daily patient care) include Drs. Gerald DiBona, Annette Fitz, Richard Freeman, Charles Hawtrey, George Kaloyanides, Richard Lawton, Kenneth Printon, Joseph Schmidt and George Theil. Additional regular members of the transplant team are Mr. Robert Huffman and Mrs. Robin Odem of Social Service, Mrs. Carol Oehlert and Mrs. Marjorie Fearing of Nursing Service, and Mrs. Donna Jacobs, secretary to the Transplant Service.

CASE REPORT: M. L. N. (TRANSPLANTED AT THE VETERANS HOSPITAL ON NOVEMBER 18, 1969)

This 33-year-old-man had chronic glomerulonephritis. In 1965 he first presented with the symptoms of chronic renal failure, including anemia, pulmonary edema and blood pressure 220/120. There was progressive deterioration of renal function despite good blood pressure control on medication. In December 1967 he first required peritoneal dialysis. In January 1968 an upper extremity arterio-venous fistula was created, and since then the fistula had been used for regular twice-weekly hemodialysis. The patient remained stable on dialysis, although there was some measurable hearing loss detected several months later. He often complained of angina-like chest pain on the artificial kidney machine whenever his hematocrit dropped below 20 per cent.

In December 1968 minimal liver function abnormalities were detected: SGOT 640 units,

BSP retention 5 per cent, and alkaline phosphatase 3.6 units. In reference to his liver function the patient remained asymptomatic. Although the liver chemistries slowly reverted to normal, this problem was a matter of continuing concern. In August 1969 a closed needle biopsy of the liver was performed. Immediately following this biopsy there was bleeding, and the patient required two units of whole blood transfusion. The biopsy specimen was interpreted as showing nonspecific hepatocellular damage not suggestive of viral hepatitis. (This problem actually delayed referral to another center for transplantation, and in the meantime our Transplantation Service was organized.)

The patient was generally considered to be a good candidate for transplantation. Careful studies revealed normal bladder function. Retrograde ureteral catheters were passed into each renal pelvis, and the pyelograms were interpreted as showing a single small kidney and collecting system on each side.

His immediate family was screened for potential donors. The patient was erythrocyte group B. A single surviving parent and three out of eight siblings had the same blood type. On leukocyte antigen testing one brother was found to be an excellent match. His leukocyte antigen profile was exactly the same except for a single questionable discrepancy out of 54 sera tested. The patient's cells did not react to the proposed donor cells in mixed lymphocyte culture, thus confirming the suspected HL-A compatibility of these two siblings. Despite many dialyses and transfusions the patient's blood did not contain antibody activity against the donor's cells (as reconfirmed on the day prior to surgery.)

The proposed donor was a young man in vigorous good health. Intravenous pyelogram was normal. Endogenous creatinine clearance was 124 and 135 ml/min. Lumbar aortogram revealed two symmetrical kidneys with a single left renal artery and some suggestion of very small right upper pole auxiliary artery. The left kidney was selected for transplantation.

As a matter of routine preparation the patient was admitted 22 days before transplantation and bilateral nephrectomy was performed. Through a transverse upper abdominal incision the peritoneal contents were explored and both kidneys were removed. The ureters were ligated and divided close to the kidney, in anticipation of their subsequent use. Guided by the previously mentioned retrograde pyelogram, the surgical team identified only a single ureter on each side. The incision was closed with No. 30 wire sutures, and the patient recovered from this operation without incident. His blood pressure subsequently remained approximately 140/85 without medication.

Eleven days prior to transplantation preliminary Imuran treatment was given in a loading dose of 4.5 mg/kg for two days, then a maintenance dose of 2.5 mg/kg daily. During this period the patient was intensively dialyzed three times a week, with transfusion on the Wednesday, Friday and Monday preceding operation.

Renal transplantation was performed on Tuesday, November 18, 1969. The donor's left kidney was removed with ureteral length and blood supply well preserved down to the iliac vessels. Care was taken to ligate and divide all lymphatic and blood vessels draining the kidney. Within seven minutes of the kidney's removal it was washed free of blood and perfused with an iced solution of physiological salt, heparin and Xylocaine. The kidney remained cool until blood flow was re-established in the re-

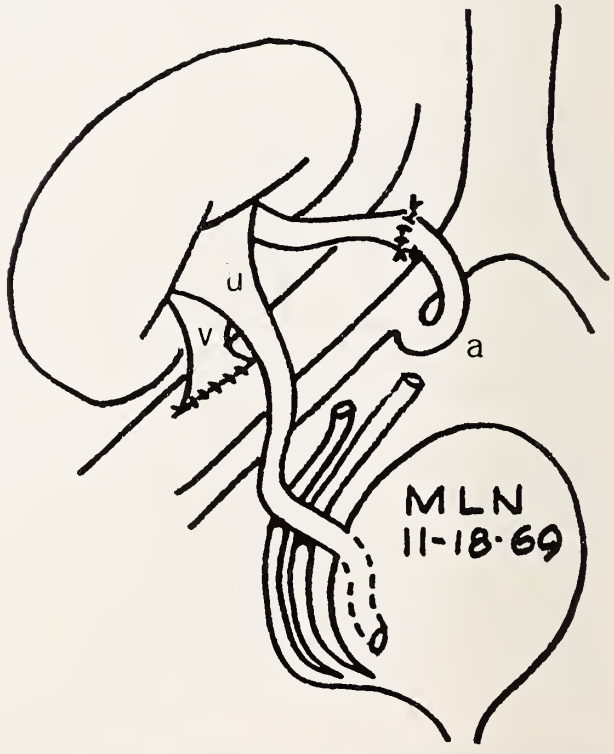


Figure 1. This illustration shows the surgical anatomy of the First Case with a designating the artery, v the vein and u the ureter.

cipient. Total ischemia time: 70 minutes. The kidney resumed function five minutes later and continued to make urine in the operating room at the rate of 800 ml/hour.

Standard technique was used to place the kidney in a retroperitoneal location within the recipient's right iliac fossa (Figure 1). The renal artery was connected end-to-end with the hypogastric artery, and the renal vein was sutured end-to-side with the recipient's common iliac vein. Rather extensive endarterectomy was needed to remove a large intimal plaque from the recipient's artery. This left the vessel wall rather thin and caused considerable secondary hemorrhage from the arterial suture line later in the operation. It was repeatedly necessary to stop for suture line repair, and the patient received six units of whole blood. Control was eventually gained without compromise to the vascular lumen.

The surgical team had planned to anastomose recipient ureter directly to donor pelvis. However, ureteral dissection revealed for the first time a near-complete duplication of the recipient ureter, making it unusable for this purpose. Accordingly, the bladder was opened and the donor ureter readily implanted through a generous submucosal tunnel.

The postoperative course has been very satisfactory (Figure 2). Urinary output returned to essentially normal levels within 48 hours. Fluid and electrolyte excretion was carefully monitored and replaced. Central venous pressure and other vital signs were well maintained without additional transfusion of blood or plasma. Twenty-four hours after surgery there was a five hour period of relative oliguria, possibly representing some degree of ureteral edema and obstruction. However, urinary output was easily re-established by Mannitol infusion. By the fifth postoperative day the endogenous creatinine clearance had stabilized at 80 ml/min. On that same day the Foley catheter was removed, and on the eighth postoperative day intravenous pyelogram showed prompt excretion of contrast medium through a completely normal collecting system.

Immunosuppression has consisted only of Imuran given in a constant maintenance dose 2.5 mg/kg daily. During the fourth and fifth postoperative weeks the outpatient endogenous creatinine clearance and serum creatinine level appeared to deteriorate. The patient was immediately brought into the hospital, where careful inulin and endogenous creatinine clearances were reconfirmed at 90 ml/min. This might conceivably represent the onset and spontaneous reversal of very mild immunological activity. One can only say that a clear-cut rejection reaction has never been identified.

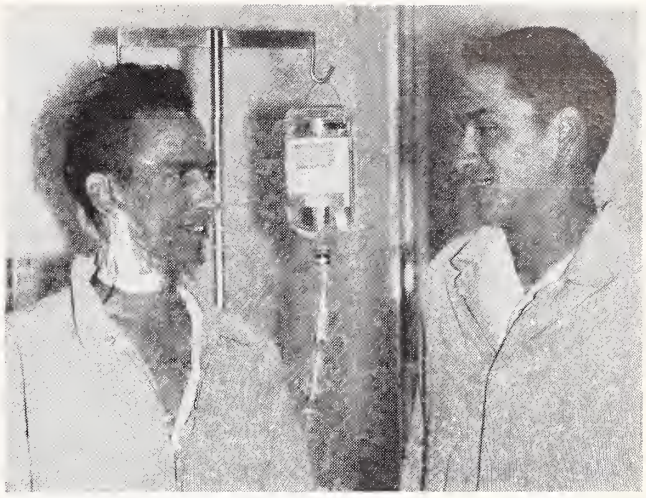


Figure 2. Shown here on the third postoperative day are the recipient, left, with jugular vein infusion, and the donor.

The patient's hematocrit was 38 per cent immediately after operation and has remained stable at 40 per cent despite the withdrawal of much blood for repeated laboratory tests. There has been clear evidence of secondary hyperparathyroidism. There has also been a salt diuresis; during the first six weeks sodium excretion exceeded 300 meq daily. High fluid intake and a 10 gram salt diet were needed to balance this semiobligatory loss.

Near the end of his third postoperative month the patient continues to feel well and has returned to at least part-time employment.

COMMENT ON THE FIRST CASE

All kidney transplant donors are carefully matched and selected under the guidance of histocompatibility typing, as performed in the laboratory of Dr. John Thompson, Department of Medicine. In particular, living voluntary donors are rigorously screened. Unless there are extenuating circumstances, we feel justified in recommending the donor operation only for an immediate family member who is proven to be HL-A compatible. Even within this framework, however, it is most unusual to see a complete lack of rejection reactivity as illustrated in our first case.

Abnormal liver function is a common finding

among dialysis patients. The cause often remains obscure, and all tests may revert spontaneously back to normal. The problem has special implications for transplantation. A possible viral hepatitis infection would be poorly handled by a patient on immunosuppression. Even in the absence of viral infection, any liver function disturbance might be confused with the toxic side effects of Imuran. If the disturbance were to flare up again, Imuran would have to be withdrawn—perhaps at a critical time.

In the urinary tract reconstruction both uretero-pyelostomy and direct implantation have been employed with good results. They provide satisfactory options for most cases. In the preliminary evaluation of every recipient's upper urinary tract, the "blocking" retrograde ureterogram technique is now routinely employed. It is otherwise easy to overlook a non-visualized or duplicated portion of the collecting system when dealing with atrophic, diseased kidneys.

The long total ischemia time reflects a very meticulous approach to vascular anastomosis, in attempt to eliminate surgical complications. The momentary cold perfusion and washout seems clearly to protect the kidney from hypoxic damage.

CASE REPORT: J. H. R. (TRANSPLANTED AT THE UNIVERSITY HOSPITAL ON DECEMBER 2, 1969)

This 29-year-old man with chronic glomerulonephritis was found to have hypertension in 1967. In May 1968 he was started on medication for blood pressure in the range of 200/140. With further deterioration of renal function an upper extremity arterio-venous fistula was created and subsequently used for regular twice-weekly hemodialysis beginning February 2, 1969. Although the patient tolerated dialysis well, he had progressive peripheral neuropathy, and there was a continuing problem with hypertension and its sequelae.

In June 1969 the patient was re-admitted to hospital with pneumonia, which improved with antibiotic treatment. In response to dialysis three time a week the patient lost some weight, and his blood pressure improved on medication. However, in mid-July the patient had progressive headache, twitching and lethargy; with a grand mal seizure on July 20 and progressive confusion, repeated minor seizures. In the absence of any localizing signs his rapid deterioration was attributed to hypertensive encephalopathy. On July 23, 1969 bilateral nephrectomy was performed as an urgent matter needed to control blood pressure. The operation was planned in close coordination with a maximal intensive hemodialysis schedule. Through a transverse upper abdominal incision the kidneys were removed with high ligation of the ureter on each side. An appendectomy was performed because the appendix was incidentally noted to be packed with hard stool and slightly inflamed. Because of very mild left renal fossa bleeding a Penrose drain was brought out through a left flank stab wound. The patient's incision was closed with non-absorbable synthetic suture material.

The patient's immediate response to the surgery was satisfactory, but 24 hours after surgery the patient had another grand mal seizure, this time with residual unilateral arm weakness. The persistent localizing signs led to the diagnosis of cerebral hemorrhage, and this was felt to be a definite contraindication to hemodialysis. The patient was managed for several days with very conservative measures including small volume Kayexalate enemas. On the sixth postoperative day, with some reluctance, the dialysis team initiated a 48 hour peritoneal dialysis. The patient's general condition improved. After 24 hours, the peritoneal fluid became cloudy with Paracolon bacillus and Staphylococcus. During this period the patient had drainage of peritoneal fluid through his flank Penrose drain. The infection was treated with penicillin, Kanamycin and Keflin. On August 1, 1969 regular hemodialysis was resumed. Very soon after surgery the blood pressure was easy to control, and the patient's mental status and general condition improved rapidly. Approximately one month after surgery a small left flank abscess became apparent and was drained through the previous Penrose drain site. The patient's incisional closure remained intact and healed well.

In the meantime the patient had been considered for transplantation. His bladder emptied smoothly and completely, with normal upper urinary collecting systems and no reflux. The patient was erythrocyte group O. Among his parents and five siblings, only one brother was found to have a similar blood type. This willing potential donor proved to have a leuko-

cyte antigen profile exactly matching that of the recipient, making him a presumed HL-A compatible donor. The recipient carried no antibodies against the donor cells, as reconfirmed on the day before surgery. It was not possible to do a complete family genetic study.

This brother donor, age 32, had good renal function with a normal intravenous pyelogram and was generally a suitable donor. However, two special problems became evident. In the first place, lumbar aortogram showed bilateral duplication of the renal arteries. The left kidney was the more favorable, with a large main artery and a much smaller upper pole artery. A recipient pelvic angiogram was performed; it confirmed that distal dissection of the hypogastric artery would make available a selection of different sized arterial branches for anastomosis. The surgical team decided to attempt anastomosis of each renal artery separately, accepting a high risk of upper pole infarction.

In the second place, the donor had palpable enlargement of the liver without splenomegaly. Selective abnormalities of body chemistry were discovered, including a "prediabetic" type of response to glucose tolerance test, 23 per cent retention of BSP, and elevated alkaline phosphatase. Serum bilirubin and SGOT were normal. Closed needle biopsy of the liver showed fatty metamorphosis and hemosiderosis. There was no scarring suggestive of cirrhosis, and the patient had normal serum iron studies. This was felt to be a completely reversible condition caused by poor dietary habits. In fact, during the subsequent two months with improved eating habits and other simple measures the patient did revert entirely to normal except for the glucose tolerance test. As there was no family history of diabetes, this glucose abnormality was attributed to the transient liver condition. With some reservations about all the preceding findings, this individual was finally accepted as a donor because of the good histocompatibility match.

With the recipient now in excellent general condition on dialysis, transplantation was scheduled. Ten days prior to surgery preliminary treatment was begun with Imuran, 5 mg/kg for three days, followed by a maintenance dose of 2 mg/kg daily. Transplantation was performed on December 2, 1969. The recipient's right hypogastric artery was dissected out beyond the second order of branching, so

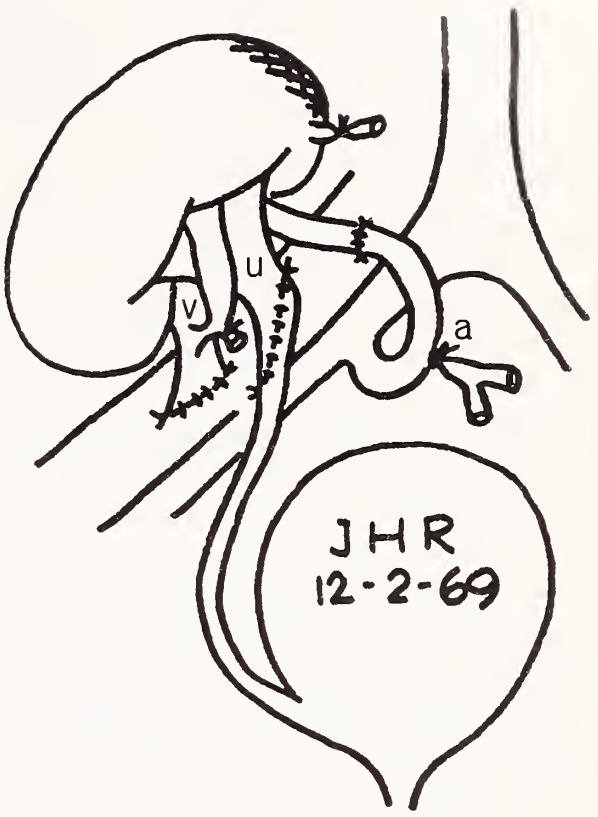


Figure 3. This illustration depicts the surgical anatomy of the Second Case with a designating the artery with side branches ligated, v the vein with communicating branch and u the ureter.

that a variety of vessels would be available for anastomosis. The donor's left kidney was dissected free with careful ligation of all blood and lymphatic vessels. The upper pole artery had a much smaller caliber than expected, and the vessel was simply ligated. There were also two intercommunicating renal veins, the smaller of which was ligated without apparent disturbance of renal blood flow. At the appropriate time the kidney was removed, perfused with cold physiological solution, and reimplanted. The remaining renal artery was connected end-to-end with the main hypogastric artery, and the renal vein was sutured end-to-side with the recipient's common iliac vein in the standard fashion. Total ischemia time was 90 minutes, and the kidney began to function approximately 10 minutes after blood flow was re-established. On the upper pole of the kidney there remained a well demarcated ischemic or infarcted area the size of a half dollar. A long oblique anastomosis was performed between the recipient ureter and donor renal pelvis (Figure 3).

The patient enjoyed a prompt, essentially

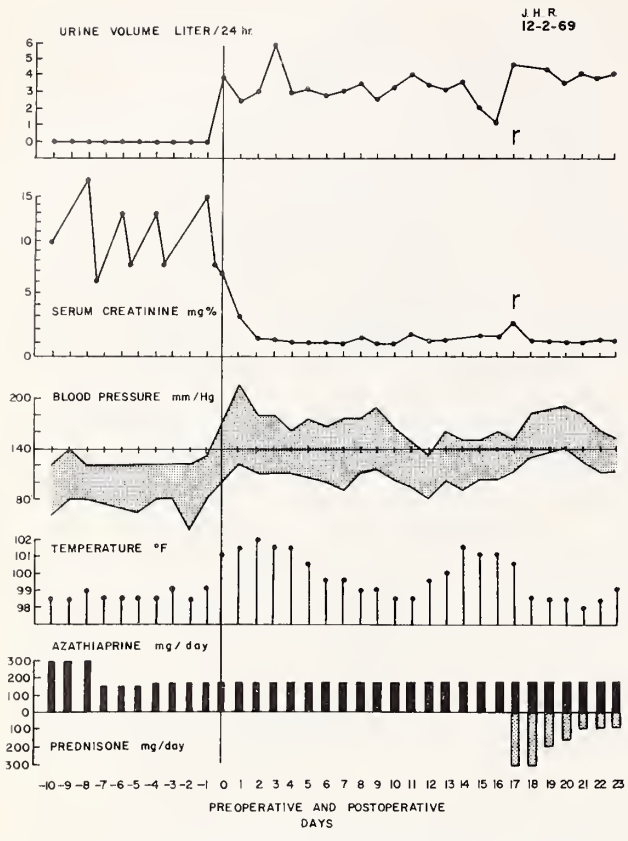


Figure 4. These graphs describe the metabolic course of the Second Case. The r designation identifies the day rejection was diagnosed and treatment began.

uncomplicated recovery from surgery (Figure 4). Renal function quickly stabilized at a satisfactory level. The days immediately following surgery were notable primarily for low-grade fever, marked recurrent hypertension, and abdominal tenderness sharply localized to a point overlying the upper pole of the transplanted kidney. On the second postoperative day peripheral vein renin levels were 1.78 nanogram of angiotensin/ml (normal value in this laboratory 0.8-5 nanogram of angiotensin/ml). These signs had all resolved by the end of the first week. On the fourth postoperative day intravenous pyelogram showed prompt excretion of contrast medium through a normal appearing urinary collecting system. The patient was discharged on the tenth postoperative day with a stable dose of Imuran, 2.5 mg/kg daily.

On the seventeenth postoperative day the patient presented with low-grade fever and a remarkable, nontender swelling of the kidney transplant. The diagnosis of acute rejection reaction was made on these clinical findings and subsequently confirmed by a period of transient oliguria and rise in serum creatinine. The patient was brought into hospital and his maintenance dose of Imuran was supplemented by Prednisone, 5 mg/kg daily. Within 24 hours there was an unmistakable diuresis and improvement in renal function back to its previously good level. The patient was discharged again six days later on a rapidly decreasing Prednisone dose. There has been no subsequent sign of rejection reactivity.

During the seventh postoperative week the patient suffered from progressive cramping mid-abdominal pain and was re-admitted to the hospital with findings suggestive of small bowel obstruction. An exploratory laparotomy was performed with identification of the obstruction and lysis of peritoneal adhesions. The patient once again enjoyed an uncomplicated convalescence and was discharged from the hospital seven days later.

In the meantime the donor had been discharged from the hospital in apparent good general condition. However, he had continued to complain of lethargy and diffuse flank discomfort without any evident cause. During the third postoperative week the donor returned for examination after 48 hours of low-grade fever. A large pocket of subfascial wound abscess was identified and drained under local anesthesia. The donor then was re-admitted to the hospital, and it was subsequently necessary to perform wider drainage under general anesthesia. The donor felt immediately better, and secondary incisional healing has now progressed without further delay.

COMMENT ON THE SECOND CASE

This case, too, clearly represents an excellent histocompatibility match as predicted by Dr. Thompson's laboratory. Initial rejection reaction was delayed until the seventeenth postoperative day and was easily reversed with medication. The patient's presenting signs and symptoms illustrate the pathology of acute rejection reaction. (1) There was a systemic response including fever and leukocytosis. (2) There was also a renal response with decreased cortical blood flow (not directly measured) and resulting decrease in glomerular filtration rate; sodium and water retention with weight gain and oliguria; and rising serum creatinine. (3) Finally, there was a remarkable degree of kidney swelling estimated to be more than half again its original volume. Because the

swelling and other findings resolved so quickly, one can reasonably attribute the swelling to such reversible processes as interstitial edema and leukocyte infiltration. It was not deemed necessary to perform a renal biopsy at that time.

The immediate postoperative hypertension and other findings are presumed to reflect a reno-vascular phenomenon secondary to the upper pole infarction. A similar course has been observed in another patient, in whom a small area of deliberate cortical infarction was also created.

The identification of this voluntary donor was a matter of prolonged, considered judgment. In view of the particular problems he presented, his acceptance is a tribute to our firm belief in the overriding importance of histocompatibility match. The donor is expected to regain completely normal general health with continuing good renal function. It is hoped that the recipient will achieve some sort of tolerant state in which the kidney is permanently accepted.

No specific break in surgical technique could be identified to explain the donor wound infection. Despite our meticulous attention to details, a deep infection did develop and may be a reflection in part of the overall lengthy time of operation.

GENERAL DISCUSSION

These two cases illustrate the extensive illness and debility caused by chronic renal failure in the uremic state. Despite regular hemodialysis on an apparently adequate schedule, there was continued progression of certain uremic complications in each of these two patients. When a good histocompatibility match can be found and transplantation is successfully performed, the resulting renal function can dramatically restore the patient's general condition and sense of well-being.

Both of these patients have enjoyed an excellent postoperative course, with many of the potential surgical and immunological complications avoided.

Hemodialysis is a crucial part of the transplantation effort. At the present time every transplant candidate receives preliminary dialysis. Even where a suitable family donor is identified and ready, the operation is delayed until renal failure is complete. Cadaver recipients often must wait a long time on dialysis before a suitably matched donor is found. Each available cadaver organ is more likely to benefit an Iowa recipient if it can be computer-matched against a large pool of Iowa patients, ready and waiting on dialysis. Drs. Kirkendall, Freeman (Dialysis Coordinator), Lawton and others are working to develop home based and community center based dialysis programs.

COST OF TRANSPLANTATION

Dialysis and transplantation costs have received wide attention recently. To substitute for the failed kidneys has proved an expensive matter in certain cases.

The figures in Table I represent the entire course of treatment to date in the cases presented.

COMMENT ON COSTS

In calculating the cost of uremic patient care, it is unrealistic to separate dialysis from surgical procedures. A typical live donor case, studied thoroughly in advance, might have electively scheduled surgery with a minimum of preoperative dialysis. Yet both cases presented here show how complications can postpone surgery and prolong the dialysis period.

The average cadaver organ recipient is committed to somewhat longer preoperative dialysis because of the interval needed to locate a suitably matched donor. It is a clear advantage to have a large pool of such patients ready and waiting on dialysis. Each available cadaver kidney would have a statistically greater chance of matching and serving an Iowa patient. Dr. Freeman and the dialysis group are prepared to assist in many ways as dialysis centers spread to other Iowa communities. Dr. Lawton and the organ preservation group have performed numerous experiments, creating at our center technical skills to harvest cadaver organs. This activity will begin soon. If other communities cooperate in this endeavor, the increased number of available organs will speed up the matching process.

Nonetheless, it is instructive to compare total surgical costs with a year of ideal outpatient dialysis. A well matched live-donor kidney should continue to function, keeping the recipient out of the hospital and providing a superior alternative to long term dialysis. Cadaver transplantation results are not as good, because the

TABLE I

	M. L. N.	J. H. R.
DIALYSIS PERIOD:		
Admission, A-V Fistula and Initial Dialysis	$ 1,392	
Professional Service, A-V Fistula	53	
Dialysis (184 @ $150)	27,600	
Dialysis (86 @ $150)		$12,900
Dialysis (19 @ $215 + Laboratory, Transfusion)		4,753
Admission, Pneumonia; Bilateral Nephrectomy (116 days)		5,570
TOTAL	$29,045	$23,223
Dialysis Costs, Outpatient Basis:		
Months of Dialysis	21 months	10 months
Total Cost	$27,600	$17,653
Cost/Year	$16,500	$21,200
TRANSPLANTATION PERIOD:		
Donor, Initial Studies	$ 145	$ 300
Donor, Transplant Nephrectomy Admission	1,068	1,323
Donor, Postoperative Care:		
Outpatient Visits	30	
Readmission X2 (Wound Infection)		862
Recipient, Transplant Admission	4,317	6,194
Recipient, Postoperative Care:		
Readmission, Diagnosis (4 days)	224	
Readmission, Rejection Reaction (5 days)		1,126
Readmission, Bowel Obstruction (6 days)		896
Outpatient Visits	195	90
TOTAL	$ 5,979	$10,791

histocompatibility match can never be quite as good. A sizeable proportion of these cases eventually fail and return to dialysis (at least to await a second kidney). Dr. Thompson's laboratory is working to make the cadaver-donor matching process more predictable, and the author is developing new immunological reagents to improve the treatment results of such cases with a less-than-optimal match.

Some attempt has been made to establish reasonable professional fees in these cases. At the Veterans Hospital, where no formal charge is made for such services, the cost account includes an estimate of extra staff time beyond the average patient's need. At the University Hospital, the bill includes $1,000 for all professional services rendered to donor and recipient during surgery and postoperative period. These levels are subject to further discussion.

A number of critical patient services are still conducted on a research basis and do not appear as cost items in this report. They include histocompatibility typing, cadaver organ recovery and special immunosuppression treatment. As these activities become crystallized into routine standard patient care, they will eventually be cost accounted in each recipient's hospital bill.

SUMMARY

Kidney transplantation has begun in the University of Iowa-Veterans Administration Program, and two illustrative case reports are presented. The accompanying cost analysis indicated that an economically feasible service can be rendered to uremic patients in Iowa.

ACKNOWLEDGEMENTS

The author extends his thanks to Robert A. Rasley, University of Iowa Hospital, and Gilbert F. Cook, Veterans Administration Hospital, for invaluable help in preparing these cost figures.

Thanks also to Mr. Eddie Kron and Mrs. Nina Forbes of the Veterans Administration Hospital Medical Illustration Service.

Tuberculosis and Bronchogenic Carcinoma

N. P. ROSSI, M.D., P. R. RECINOS, M.D., and
J. L. EHRENHAFT, M.D.
Iowa City

Tuberculosis and bronchogenic carcinoma are two very common diseases the interrelationship of which has been of considerable medical interest for over a century and which still has important implications in clinical medicine today. Bayle,[1] in 1810, is credited with first documenting the coexistence of these two diseases in the same patient, and Penard,[2] in 1846, probably reported the first clinical case of coexistent bronchogenic carcinoma and pulmonary tuberculosis. However, from that point on, medical thinking about the relationship between the two diseases has been characterized by continued reexamination and controversy.

In 1854, Rokitansky[3] postulated that the two diseases were antagonistic, since they seemed not to affect the same organs. He noted that tuberculosis was common in the epididymis, and that cancer was rare there. In the ovary cancer was common and tuberculosis was rare, and he felt that perhaps some similar relationship might be established for cancer and tuberculosis of the lung. This concept was generally accepted for many years, and it was reinforced by a statistical study in 1929 by Pearl,[4] who reexamined 6,670 postmortem records. In 186 autopsies of patients who had died from a malignancy, 6.6 per cent had had tuberculosis, as opposed to 16.3 per cent in the same number of persons who had died from diseases other than tuberculosis. He supported Rokitansky's view, and he even suggested treating carcinoma with iatrogenic tuberculosis! Others, such as Hueper[5] in 1930, and Desmeules[6] as recently as 1955, have supported this contention of Rokitansky's.

There are, however, two other points of view —each supported by a number of reports in the literature. One alternate view is that the two diseases coexist by chance, and that such an association has no particular significance. Those who have supported this view have included Cooper[7] (1932), Hoffmann[8] (1929), Stein[9] (1938) and Drymalski[10] (1948). Drymalski reported that on sputum analysis 20 per cent of 56 patients with bronchogenic carcinoma had acid-fast bacilli, but that on pathologic examination only a third of that 20 per cent demonstrated active tuberculosis. In one half, no demonstrable tuberculous focus was found, and he concluded that the association of the two diseases was fortuitous, since 10 to 20 per cent of adults dying of causes other than carcinoma of the lung have acid-fast bacilli, and in his opinion approximately 5 to 10 per cent of the people in the United States harbor living tubercle bacilli.

Those who hold a third point of view maintain that there is a definite association between the two. Broders,[11] who summarized the literature in 1919, found that the two diseases were associated in 16.3 per cent. Barron[12] and Fried[13] incriminated old tuberculous scars and cavities as precancerous lesions. Schwartz[14] (1956) believed that tuberculosis is the chief etiologic factor in carcinoma, and in a pathologic study found cancer related to bronchial scars, presumably the results of tuberculous bronchitis or adenitis. Cruickshank,[15] in 1940, showed statistically that the distribution of tuberculosis closely follows that of bronchogenic carcinoma in various population areas in England.

These are the three principal viewpoints that have been held during the past century concerning the relationship between these two diseases. By the end of World War II it was certainly accepted that the two diseases are not mutually exclusive, and that both may exist and flourish within the same patient. Then, in the decade of the 1950's, attention turned to the question of whether there might be any common etiologic or causal connection between the two.

In regard to the incidence, some interesting studies have been brought forth. Greenberg *et al.*,[16] over a six-year interval, found eight cases

Dr. Rossi is an associate professor, Dr. Recinos is a resident, and Dr. Ehrenhaft is a professor in the Department of Surgery at the U. of I. College of Medicine. This paper was read at the meeting of the Iowa Academy of Surgery, in Ames, in September, 1969.

of coexistent carcinoma and tuberculosis in 1,232 patients hospitalized for tuberculosis. Gerami *et al.*,[17] over an 18-year span, found 27 cases of carcinoma and tuberculosis in 6,622 patients hospitalized for pulmonary tuberculosis. Twenty-two per cent of patients with carcinoma of the lung in Rosenblatt's series[18] had previous pulmonary tuberculosis. Steinitz[19] had surveyed the population of Israel over the 1960 to 1964 period, and although she reported that the coexistence of the two diseases in patients admitted to the hospital might not have been significant, she showed from a nationwide survey based upon two population-based registries that male tuberculous patients run a five-fold greater risk of dying from carcinoma of the lung, and female patients a ten-fold greater risk than does the general population. According to United States vital statistics, 24 per 100,000 people of both sexes, in 1964, died of carcinoma of the lung, but among males only, 41.4 per 100,000 died of this disease. If one compares the death rate from carcinoma in tuberculous populations with the death rate from that cause in the general population, he sees that there is an increased mortality from carcinoma in tuberculous patients. However, it has yet to be shown that there is a causal relationship between the two diseases, or that they have a common specific etiologic agent. Very likely no such relationship exists.

DISCUSSION

We reviewed the records of 1,459 tuberculous patients admitted to the Oakdale Sanatorium* from January, 1960, to April, 1969, and found, among them, 25 cases of concomitant carcinoma of the lung. The incidence in this series was 1.7 per cent. The extent of the tuberculosis was classified as minimal in one patient; moderate in one; and far advanced in 23. As regards the activity of the tuberculosis at the time that carcinoma was diagnosed, in three cases it was active and in 22 cases it was inactive. In our series we found no cases in which the carcinoma had reactivated a previously existent tuberculosis, but there is no doubt that this sometimes occurs. This view has been supported by Nuessle.[20] Our experience, however, agrees with that of Woodruff,[21] who indicated that such a course of events is not the usual one. The PPD was active in 24 of our patients, and in one patient with very active tuberculosis there was a state of anergy. Lindskog[22] compared the reactions to tuberculosis in 100 known patients with bronchogenic carcinoma, and found that the PPD was positive in 95 per cent of them. A control group, in the same hospital at the same time, showed 80 per cent positive reactions. The appearance of carcinoma in a tuberculous patient will not convert his skin test from positive to negative, as was once proposed. In all of our patients, the diagnosis of tuberculosis was confirmed bacteriologically.

The histologic examinations showed that five of the carcinomas were adenocarcinomas; 14 were squamous cell carcinomas; two were undifferentiated carcinomas; one was an oat-cell carcinoma; and three were mixed. A higher incidence of squamous cell carcinoma with chronic inactive tuberculosis has been reported, but we found no correlation between the histologic appearance of the carcinoma and the activity of the tuberculosis. On the basis of the pathologic material, an attempt was made to find a correlation between the location of the tuberculosis and the location of the lung carcinoma, and although in 17 (68 per cent) of the specimens we did find that the lesions were in the same general area, in the remainder they were in different locations or had no obvious geographic similarity. Histologically our study was not detailed enough to demonstrate whether any of the carcinomas had any relationship to so-called parenchymal scars. Lindskog, in an analysis of his 100 cases, found that 22 per cent of his 95 patients with bronchogenic carcinoma and positive tuberculin skin tests had primary parenchymal foci radiologically separate from the tumor mass. We agree with him that one cannot find any definite, reproducible or significant radiologic correlation between the location of the tumor and the tuberculosis.

An analysis of the diagnostic problems and of their effect upon the therapeutic result provides the most important lesson to be learned from a review such as this. In our 25 cases, diagnosis was usually made too late—frequently at autopsy—and the average interval between diagnosis of tuberculosis and diagnosis of carcinoma was 37 months. At the time of this report, 19 of the patients with both diseases are dead—17 of them from lung car-

* We wish to thank Dr. William Spear for his kind assistance in making those records available.

cinoma. Six are still alive, but five of those are in the terminal stages of the disease, and only one is apparently free of disease 18 months after pulmonary resection.

This record has already been bettered. Tuberculosis need not lessen the chances of our curing a patient with cancer. We now know that if a patient has chronic, inactive tuberculosis he should be followed at regular intervals, and the possibility that carcinoma is lurking in the background should be thought about and looked for. All experience—some of it sad—indicates that carcinoma must be suspected in tuberculous patients. (See Table 1.)

TABLE I

SUSPECT CANCER IN A PATIENT WITH CHRONIC TUBERCULOSIS WHEN:

1. The patient is a heavy smoker;
2. He is over 40;
3. He shows progression of disease in an area where infiltrates are clearing on drug therapy;
4. Atelectasis of a segment or lobe appears;
5. The patient has a long-standing history of tuberculosis even though inactive or arrested;
6. New lesions appear in a known tuberculous patient under therapy whose X-ray has been stable;
7. A unilateral hilar enlargement appears.

SUMMARY

1. There is an increased incidence of carcinoma in patients with chronic tuberculosis. 2. The appearance of bronchogenic carcinoma in such patients may at first be obscure and insidious in origin. The diagnosis will be made only when this relationship is understood and looked for. 3. There are no unusual pathologic, radiographic or symptomatic manifestations of carcinoma in tuberculous patients. The criteria by which one must suspect carcinoma have been learned from hard experience, and they have been summarized.

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Continuing Medical Education Programs

Physicians attending the 1970 Annual Meeting of the Iowa Medical Society are invited to stop at the University of Iowa College of Medicine Continuing Medical Education Booth. Dr. Richard M. Caplan, Director, Office of Medical Education, will be present to discuss new ideas and programs. The College in this and other ways is attempting to provide a more active educational service to Iowa physicians.

The 1970 IMS Annual Meeting will provide a good opportunity to visit with Dr. Caplan about participation in the preceptorship program and other developing programs.

Vasodilators in Prevention and Treatment of Ischemic Stroke

JOHN R. TAYLOR, M.D.
Iowa City

MUCH OF MODERN THERAPY of ischemic cerebrovascular disease is directed toward increasing blood flow through diseased arteries. Recent literature contains frequent reports of the use of surgery and anticoagulation in this regard, and both of these have brought at least limited success. Less attention, however, has been given the vasodilators, in spite of their use by many physicians. Since they are likely to continue being used until ways are found to prevent the atherosclerotic encroachment in the first place, a review of their place in therapy is pertinent.

CARBON DIOXIDE

The effects of altering the alveolar concentration of carbon dioxide are well known. Some of them result from the ability of CO_2 to alter vasomotor tone.[1, 2] If normal subjects breathe a mixture of 7 per cent carbon dioxide and 93 per cent oxygen for 10 minutes, they will experience cerebral vasodilatation, an average rise of 10 mm. Hg in $paCO_2$, a modest rise in systemic blood pressure,[3] and anxiety. The effect on cerebral vessels is so consistent that their failure to react is considered evidence of less than normal autoregulation. In ischemic areas, however, the blood vessels may be maximally dilated, presumably because of local acidosis and CO_2 production. Lassen,[4] among others, has even found that the arteries in such areas are providing a blood flow in excess of the ability of damaged tissue to extract the oxygen, producing what he calls "luxury perfusion." If this be the case, then the findings of other investigators that further dilatation of surrounding vessels by means of vasodilators can lead to an "intracerebral-steal syndrome,"[5-7] tends to contraindicate the use of vasodilators. Instead, hyperventilation might be reasonable, producing hypocarbia, a resulting increase in resistance of the surrounding normal vessels, and a shunting of blood into the damaged area (the "Robin Hood syndrome").[8] Closer scrutiny of the conclusions drawn from these findings reveals some discordance, however. For example, a true state of luxury perfusion could not benefit from more profusion, whether induced by hyperventilation or any other mechanism.

Clinically, there has been some justification, though by no means substantiation, for the aforementioned conclusions. Fazekas and Alman[9] had 22 subjects inhale 5 per cent CO_2 and 95 per cent oxygen for five minutes, and found that nine of them did not experience an increase in cerebral blood flow. Paulson[10] studied 10 patients, measuring local areas of blood flow by the intracarotid xenon^{133} technique, and found areas of focal loss of autoregulation in all of them. Other investigators have made similar observations regarding some of their patients, but have found that others of them responded normally to CO_2 inhalation with an increase in blood flow.[11, 12] Hegedus and Shackelford[13] found rapid improvement in several of their patients who had been suffering ischemic episodes. Thus, although many patients with ischemic brain lesions apparently do lose vascular autoregulation, enough of them retain this capacity so that carbon dioxide inhalation therapy cannot as yet be entirely discounted.

Carbon dioxide has the advantage of potency and the disadvantage of cumbersomeness in administration. It is available commercially as a 5 per cent CO_2 and 95 per cent O_2 mixture, and it is inhaled for 5 to 10 minutes, hourly, by mask. It produces apprehension and mild acidosis, but is generally low in toxicity. The Rehn tube or a similar rebreathing device can produce an increase in CO_2 concentration, but of course the increased alveolar oxygen tension obtained with the commercial mixture is lacking. Acetazolamide can chemically induce an effect resembling that of CO_2 administration,

Dr. Taylor is a member of the staff in the Department of Neurology at University Hospitals, and is administrator of the Stroke Educational Project of the Iowa Regional Medical Program.

and probably can maintain it longer,[14] but the quantitative relation is unclear.

PAPAVERINE

Papaverine is a well known drug that is available in several forms. It is a smooth-muscle relaxant with a particular action on arterial muscle. Although it reduces the irritability of cardiac muscle, it also prolongs the refractory period, and consequently large intravenous doses may cause cardiac arrhythmia.[15] Rapid intravenous administration readily produces hypotension in animals.[16]

Papaverine is commonly used as a cerebral vasodilator, though both Shackelford[17] and Handa *et al.*[16] believe that CO_2 is more potent. Gilroy and Meyer[18] employed it in intermittent intravenous doses in a randomized group of acute stroke patients. They used 500 mg. of papaverine hydrochloride in 1,000 cc. of 5 per cent dextrose in 0.2 N sodium chloride, injected during alternate 8 hr. periods for 10 days, and found the *quality* of survival in the treatment group greater at a statistically significant level. However, the numbers of survivors in the treatment and the control groups were not significantly different.

It is commonly believed that papaverine prevents transient ischemic attacks,[19] but controlled studies to prove the point are unavailable. "Cerebral arteriosclerosis" is frequently diagnosed in elderly patients manifesting a rather vague syndrome consisting of intellectual decline, tremor, loss of socialization, evidence of remote arteriosclerosis, and occasionally some motor impairment. Such patients have apparently benefited from oral papaverine.[20] Again, however, randomized controlled clinical studies are unavailable.

Side effects of papaverine are minor, and usually are easily detected. Hypotension is the most feared in subjects with cerebral vascular occlusive disease, and one should be careful to avoid this in all patients on the drug. Sedation occurs in a few, but it is not ordinarily troublesome. Apprehension has been reported. Phlebothrombosis has been observed when the drug has been given by the intravenous route, and a mild degree of it is rather common.

CYCLANDELATE

Cyclandelate (Cyclospasmol), a derivative of mandelic acid, was initially found to abolish evoked spasm in intestinal strips.[21] The subsequent discovery that it produced vasodilatation led to its use in vascular disease. It is not an acetyl-choline antagonist of any significance, and its atropine effect is minimal.[22] Poorly soluble in water, it is available only in the oral form. The side effects, which include sweating, flushing, tingling, dizziness, gastric irritation and headache, are usually mild. Hypotension has not been reported.

DOSAGE TABLE

Drug	Dose	Route
Papaverine	300-600 mg/day	orally
	500 mg q.o. 8 hr.	i.v. drip
Cyclandelate	400-1600 mg/day	orally
Isoxsuprine	30-80 mg/day	orally
Carbon Dioxide ..	5% CO_2 in 95% O_2	5-10 min. inhalations hourly

This drug increases cerebral blood flow in some human subjects.[23-26] Clinically, its beneficial effects are varied. Ball and Taylor[27] used the preparation in 16 patients with chronic cerebral vascular disease, and used 16 controls. Some aspects of mental function were found to have been significantly improved.

Though uncontrolled, the 1961 study by van der Drift[28] provides interesting data. Of 120 patients treated only with cyclandelate, 74 (61.6 per cent) improved, though eight subsequently suffered a paralytic stroke despite having fewer transient attacks. Of the entire 120-patient group, 20 (16.6 per cent) eventually sustained a stroke. An attempt to compare this treated group with natural history studies conducted by other investigators is somewhat hazardous. However Marshall[29] studied the natural history of transient ischemic attacks in 60 patients (uncomplicated by prior infarction), and reported that 33 (55 per cent) ceased having attacks the first year. Baker[30] reported that 52 per cent of 53 patients without prior stroke ceased having transient ischemic attacks within one year. Some received anticoagulants. Twenty per cent ultimately suffered a stroke. In a study by Acheson and Hutchinson,[31] 82 patients who initially presented with symptoms of transient ischemia were followed an average of 40 months. Nineteen (23 per cent) had minor stroke with complete recovery, and 38 (46 per cent) of the others ceased having attacks. So 59 (69 per cent) of the 82 were "in normal

health" at the end of the study period. Eighteen (22 per cent) had disabling or fatal cerebrovascular events, and the remaining seven died from other causes.

Although these comparisons are interesting, and although they suggest that cyclandelate is of limited value in treating transient ischemia, the parallelism of the populations studied is so doubtful and the investigators' objectives sufficiently tangential so that any such conclusion is rather weak. Its effectiveness in acute processes has not been established, but its side effects are minimal, and there can be little harm in its use.

ISOXSUPRINE (VASODILAN)

Isoxsuprine (Vasodilan) is a smooth-muscle relaxant having minimal adrenergic blocking action. Evidence, in the English-language literature, that it is a cerebrovascular relaxant is probably adequate,[32] though it is by no means overwhelming. Its toxicity is low, the LD_{50} (oral) in mice being 1,100 mg./Kg., and the chief toxic symptoms that are observed in surviving animals consist of ataxia, tachycardia and respiratory depression.[33] Transitory blood-pressure decreases have been noted in human patients.[34]

Clinical studies are not numerous, but in two of them,[34, 35] patients with cerebral arteriosclerosis were found improved in certain parameters of mental function. A third study[36] found a trend toward fewer ischemic attacks in treated patients. Further clinical work is clearly needed before a definite conclusion can be drawn about its usefulness in cerebrovascular disease.

SUMMARY

1. Vasodilatation may be maximal in the ischemic cerebral stroke, and any further induction of dilation by chemical means may be useless or even harmful. Despite this theoretical objection, it is possible that the patient may be benefitted by this therapy, particularly in an evolving stroke. This appears to have been best established for CO_2 inhalations and for intravenous papaverine. Careful observation of the patient must be maintained during treatment, however, since either a paradoxical decrease in blood flow to the ischemic area or a systemic hypotension may increase the neurologic deficit.

2. Although the possibility that vasodilator drugs can ameliorate transient ischemia has been suggested, it has as yet been indequately studied. Systemic hypotension from whatever cause is known to precipitate neurologic symptoms in individuals with cerebrovascular disease, and caution should consequently be exercised in the use of these drugs.

3. There may be some beneficial effect from the use of vasodilator drugs in the syndrome of "arteriosclerotic dementia," though it has not been established that the benefit is due to vasodilatation.

4. The usefulness of vasodilator therapy is not sufficiently certain to permit anyone's recommending its routine use, to the exclusion of better-proved remedies for stroke syndromes.

5. Differential cerebral-flow studies suggest that the hemodynamic response to cerebrovascular ischemia is not stereotyped, and as such studies become more generally available, we may find that although some patients benefit from induced dilatation, others profit from the reverse.[37] Until the method of evaluation is more generally available, prudent physicians must depend upon frequent clinical observations in assessing the effects of their therapy.

6. The studies that have been reviewed here are ones necessary for the initial evaluation of any therapy, but at this point they are so indecisive as to leave the practitioner in a dilemma. The variability in the courses of patients with cerebrovascular disease is so great that the modest therapeutic benefits claimed for these drugs lack any considerable statistical validity. Only when large numbers of treated patients have been followed at length, together with adequate control groups, will the physician be able to prescribe such remedies with confidence.

ACKNOWLEDGEMENT

The assistance of Dr. Maurice W. Van Allen, a professor of neurology at University Hospitals, Iowa City, in the preparation of this paper is gratefully acknowledged.

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AAP Revises Redbook

The American Academy of Pediatrics has released its newly-revised 16th edition of the *Report of the Committee on Infectious Diseases* (REDBOOK). Several changes have been made in the 16th edition of the REDBOOK. For example, more detailed information has been included concerning general factors relating to active and passive immunization, and to special requirements for foreign travel.

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CBS-TV to Present Series On "Health in America"

"Health in America" is the title of a three-part, hour-long series to be telecast by the Columbia Broadcasting System on Monday, Tuesday and Wednesday, April 20-22, at 9 p.m. CST, over its national network.

The advance announcement from CBS states: "In an extraordinary three-part series, broadcast on consecutive evenings, CBS News investigates medical care in the nation. Exploring both the quality and the cost, it covers the subject from the viewpoint of both the patient and the practitioner, as well as the drug company."

President's Page



Traditionally, the April issue of the JOURNAL is designated the UNIVERSITY issue. The designation this year has added significance. This is the centennial year for the College of Medicine.

In a concluding act as your president, I should like to extend the Society's congratulations and best wishes to the students, faculty and alumni as they observe this historical milestone. Various commemorative events will occur this year; these will honor the past and look to the future. The Society is pleased to have been included in the planning of these events.

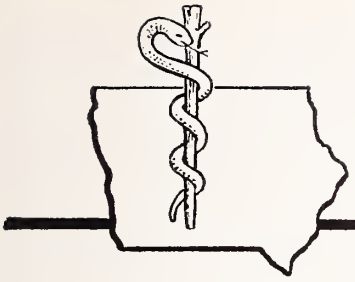
The past about which we speak is recaptured interestingly in this issue by Dr. Bean; I call your attention to his historical treatise. For contrast, the past with today and tomorrow, you are encouraged to read Dr. Bonney's report on the University's Organ Transplant Program.

A fine spirit of cooperation exists between the College and the Society. This year, for example, the two bodies have worked closely in presenting about the state 15 public programs on the status of health care in Iowa. We look forward to a second century of similar cooperation.

My personal thanks to the many Iowa physicians who have served the Society during my presidency. I appreciate this good help. I will with honor and confidence pass the president's gavel to Jack Sunderbruch, M.D., at the 1970 Annual Meeting this month. I hope to see you there.

Wm M. Kingsley MD

President



Editorials

A CENTURY OF DISTINGUISHED SERVICE

On this the centenary of the University of Iowa College of Medicine it is particularly fitting for the medical profession and the citizens of Iowa to pay homage to the institution and its staff.

It defies both imagination and realism to assess the impact of the College of Medicine upon the state and the nation during these 100 years. Its contribution to the welfare of mankind is beyond measure.

In this College of Medicine issue of the JOURNAL, we wish to express profound gratitude to the administration and the staff for their cooperation and support and for the many papers submitted to the JOURNAL for the benefit of our readers.

IOWA PHYSICIANS ANALYZE REAR-END COLLISIONS

Two very busy practicing physicians in Des Moines are to be complimented and commended for the publication of a new book by Charles C Thomas. The book is entitled, "Injuries Following Rear-End Automobile Collisions," and the authors are William D. deGravelles, Jr., M.D., and John H. Kelley, M.D., Chief of Physical Medicine and Rehabilitation, and Chief of Orthopedic Surgery, respectively, Younker Memorial Rehabilitation Center.*

A foreword by Carroll B. Larson, M.D., Chief of the Department of Orthopedic Surgery, University Hospitals, Iowa City, commends the authors for challenging (1) the confusion and (2) the multiplicity of opinions concerning the complaints of pain in and about the neck following rear-end automobile collisions. The frequent absence of consistent physical or radiologic signs have failed to identify pathologic changes in tissues which could positively relate symptoms with injury. The frequency of this type of accident and the frequency of symptoms which follow have resulted in a multiplicity of opinions, unfounded on fact, in an effort to explain the symptoms. The authors challenge many of the diverse opinions and search for facts to relieve the frustrations of physicians, patients, and the legal profession.

"The search has cast some light on the problem . . . the authors are commended for confrontation rather than the acceptance of continued frustration and their reward will be disappearance of mere opinions in those areas where enlightenment now exists."

In the preface the authors assert that in their experience, persons having various symptoms after being involved in a rear-end collision present a fairly consistent clinical picture, course and recovery. They feel that accidents of this kind may result in symptoms of varying severity, but in general they are similar from case to case and follow a similar course to recovery. The book is written in an effort to clarify the clinical picture of the so-called whiplash injury and to bring order out of the confusion which exists concerning this injury.

The Iowa authors hope to establish the fact that the signs, symptoms and clinical course

* deGravelles, W. D., Jr., and Kelley, J. H.: Injuries Following Rear-End Automobile Collisions. Springfield, Illinois, Charles C Thomas, Publisher, 1969.

Editorials continued...

fall into a pattern which constitutes "a clear-cut, separate, and distinct injury syndrome and that the prognosis for recovery of the injured structures is good." They would prefer that the term "whiplash" be abandoned and the injury be referred to as "cervical strain following rear-end collision."

The authors rely upon a statistical approach to the problem and contend this is a valid way to procure reliable data. With the help of trained personnel several surveys were conducted and reported. The first of these surveys consisted of interviews with 173 persons involved in rear-end collisions in Iowa and all reported cervical injury. These individuals were ones to whom an insurance company paid consecutive claims for injuries over a period of eight years. A control study was made in a rural Iowa community of 200 randomly selected adults to determine the frequency of neck and back pains in the general population. To determine the frequency of various types of automobile accidents, data is presented from records of the Iowa Department of Public Safety for the year 1963 and for the city of Des Moines for two months in 1964. Telephone interviews were conducted with 156 of the drivers who were in rear-end collisions. This was done to procure information concerning the number of persons injured, their position in the car, etc. Lastly, an analysis was carried out on some 37,000 personal injury settlements by eight insurance companies which involved 5,500 settlements of claims for neck injuries.

The volume emphasizes that much of the confusion about the nature, severity and outcome of the injuries sustained in rear-end collisions is due to the inclusion in the literature of injuries suffered from accidents other than "pure" rear-end collisions. "Pure" collisions are those in which the forward car, either stopped or moving, is struck straight on in the back by another car traveling in the same direction. This results in a sudden hyperextension of the head followed by a rebound hyperflexion. It is this mechanism which appears to cause the injury to the soft tissues and the symptoma of the clinical entity "cervical strain following rear-end collision."

Study of this small volume will help the reader better understand this common injury, its course and outcome. Suggestions are offered concerning treatment to relieve symptoms and facilitate recovery.

AZOTHIOPRINE IN THE TREATMENT OF THROMBOCYTOPENIC PURPURA

Drs. Doan and Bouroncle, of the Department of Medicine at the Ohio State University College of Medicine, have had an extensive experience in the treatment of idiopathic thrombocytopenic purpura over many years. Splenectomy and corticosteroids, they found, proved to be the treatments of choice. However, in some patients the disease was refractory to these measures, and in others it was necessary to administer the corticosteroids in large doses over long periods, with resultant undesirable or even dangerous complications. In a series of 271 patients with this disease, only 7.7 per cent were refractory to both methods of treatment.

Prompted by the generally accepted concept that some cases of thrombocytopenic purpura may be the result of an autoimmune reaction, Doan and Bouroncle started using the antimetabolic azothioprine concomitantly with corticosteroids in treating patients refractory to conventional therapy. Their paper presented results achieved in treating 17 patients in this manner over a four-year period.*

The group of 17 patients consisted of 10 females and seven males, and their ages ranged from seven to 70 years. Azothioprine therapy was restricted to patients with idiopathic thrombocytopenic purpura. Those with a secondary disease, such as the transitory post-

* Bouroncle, B. A., and Doan, C. A.: Treatment of refractory idiopathic thrombocytopenic purpura. JAMA, **207**:2049-2052, (Mar. 17) 1969.

viral form frequently seen in children, were excluded. Before azothioprine therapy, 14 of the 17 patients had undergone splenectomy, but had failed to respond and were continuing to have the characteristic features of the disease.

Four patients had undergone splenectomy from six to 20 years prior to the relapse that necessitated initiating azothioprine therapy. Three patients had not undergone splenectomy because surgery had been contraindicated by primary cardiac disease.

Twelve of the 17 patients had been treated with prednisone, 30 to 100 mg. per day, prior to starting azothioprine. The duration of prednisone therapy had varied from two to 18 months. A few of these patients showed an improvement in platelet level only as long as the doses of prednisone were maintained at high levels. All 12 patients given prednisone were judged to have failed to respond to the treatment.

Because of the possible toxic effects of azothioprine, patients were checked frequently. At first blood counts were done weekly, but later they were done at monthly intervals. With the exception of one patient who had diabetes, all of the group were treated simultaneously with prednisone and azothioprine, since the medications appeared to have a synergistic effect even in patients who were refractory to corticosteroids. As the platelet counts reached near-normal levels, the prednisone was gradually decreased, and when the counts reached and were maintained at normal, it was discontinued. The administration of azothioprine was reduced in the same manner as the prednisone, though more slowly in order to assure a continued remission of the disease.

In five of the 17 patients treated with prednisone and azothioprine, the response was excellent—a complete hematologic and clinical remission. In two patients the duration of azothioprine therapy was only three to four months; in the other three patients azothioprine had to be given in varying doses for eight to 26 months before the platelet counts stabilized at normal levels. In seven patients the response to therapy was good, and lasted from one to 12 months; one patient died from cardiac disease; the other six patients still require azothioprine to maintain normal platelet levels. Two patients had fair responses after nine and 38 months, showing some improvement in platelet levels but failing to reach or maintain normal counts. In three patients the combined azothioprine and prednisone therapy was classified as a failure after five and nine months.

The only toxic effects of azothioprine consisted of moderate leukopenia in two patients. However this was rapidly reversible upon reduction of the dose of the drug. It was apparent from the results of this study that the dose of azothioprine necessary to induce a remission of thrombocytopenic purpura did not induce cellular depression of the bone marrow or induce a harmful degree of immunosuppression in the patients treated. No evidence of an increased incidence of infection was observed in any of the patients treated.

The authors point out that the effect of azothioprine on the platelet count does not become apparent for weeks. For this reason they consider it advisable to begin treatment concomitantly with prednisone. As the platelets reach normal levels, they recommend that the prednisone be gradually reduced and discontinued. If the platelets then remain normal, the dose of azothioprine is gradually lowered and finally discontinued. However, in their experience, in order to maintain a remission one must prolong azothioprine therapy for a minimum of three months, and in some patients for over two years. They found that steroids appear to have an additive effect in maintaining a remission, even in patients who had previously failed to respond to maximum and prolonged corticosteroid therapy alone.


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Editorials continued...

WHEN IS MASTOIDECTOMY NECESSARY?

Since the introduction of sulfa drugs and antibiotics, infection of the mastoid is extremely uncommon. In a recent article, Miglets and Harrington, Ohio State University College of Medicine, confirm that mastoiditis as a complication of acute otitis media is a rarity due to the widespread use of antibiotics.* On the other hand, chronic infection of the mastoid is frequently seen. This is confirmed by the report that during three years (July 1965 to July 1968) mastoidectomies were performed on 367 patients at the Ohio State University Hospital and the Children's Hospital of Columbus.

The failure of antibiotic therapy to clear up chronic suppurative otitis media and chronic mastoiditis is attributed to the fact that the condition is usually due to a cholesteatoma or the formation of thick granulation tissue within the mastoid. These conditions do not respond to antibiotic therapy. As a consequence, the majority of patients with chronic suppurative ear disease require mastoidectomy to eradicate infection.

The authors point out that frequently physicians are misled and lulled into a false sense of security by the insidious nature of chronic mastoiditis. In most cases there is only a history of chronic ear drainage and an associated hearing loss. On examination there is a defect of the tympanic membrane which may vary considerably in size and location. In most patients who have a cholesteatoma, the perforation is in the posterior superior quadrant extending to the margin of the drumhead. Squamous epithelium of the ear canal grows into the middle ear and mastoid to form a cholesteatoma. The size of the perforation does not necessarily reflect the size of the cholesteatoma or the extent of the disease in the middle ear or mastoid.

Large central perforations are usually associated with a chronic granulation tissue type of chronic mastoiditis or with malfunction of the eustachian tube. Occasionally, a cholesteatoma may be seen with a central perforation. Tenderness over the mastoid is usually not found in patients with uncomplicated chronic mastoiditis.

It is noted that discharge from the ear in chronic mastoiditis may be of two types. When associated with eustachian tube dysfunction, usually seen in central or anterior tympanic membrane perforations, the discharge is frequently mucoid, and it may be intermittent, increasing when the patient develops an acute upper respiratory infection or when water gets into the ear. In patients with cholesteatoma the discharge is thick, scanty and foul. In chronic mastoiditis gram negative organisms are cultured from the discharge, in contrast to gram positive organisms in acute infections.

The majority of the patients with chronic mastoiditis had some degree of conductive or middle ear type of hearing loss. This is usually due to fixation or actual destruction of some part of the ossicular chain.

The authors emphasize the potentially dangerous nature of chronic suppurative ear disease; they cite the hazard of the extension of the infection from the mastoid cells into the cranial cavity or into the labyrinth. Ten of the 367 patients with chronic mastoiditis were admitted to the hospital with serious complications and in all of them a cholesteatoma was the etiologic agent.

As a consequence of the erosion of bone by cholesteatoma, infection may result in epidural or subdural abscess, meningitis or septic thrombosis of a venous sinus. Extension of infection into the temporal bone may result in labyrinthitis or facial nerve paralysis. The authors point out that multiple complications are common. The aforementioned 10 difficult cases in the series presented 20 complications, most of them intracranial. Only one patient died, but for most convalescence was prolonged and in four of the group there were residual neurologic defects.

* Miglets, A. W., and Harrington, J. W.: Complications of chronic mastoiditis. OHIO STATE MED. J., 65:1219-1225, (Dec.) 1969.

According to the report, chronic infection of the mastoid may be present for many years before complications develop. These then may occur suddenly with the signs and symptoms of a full blown intracranial infection. If there is a spread of infection into the temporal bone, it is heralded by the symptoms of vertigo, pain in the ear, and facial weakness. Case studies are presented to illustrate the various complications encountered by the authors. For those of us who practiced way back when, these complications call to mind critically ill patients with complications of acute otitis media.

The report of the Ohio experience is concluded with the statement, "the widespread use of sulfamides and antibiotics has decreased the complications of acute otitis media considerably. However, intracranial complications still occur, chiefly as the result of neglected chronic mastoiditis. With modern anesthesia and otologic technics, mastoidectomy is a safe procedure. In the majority of patients, this is the only effective way of preventing these serious complications from occurring."

DISCIPLINE: A CENTRAL ISSUE OF OUR TIMES

In the December, 1969, issue of ARCHIVES OF INTERNAL MEDICINE, Dr. Dana W. Atchley wrote on the subject "Discipline: A Central Issue of Our Times." Though directed primarily to the medical student of today, several paragraphs deserve the critical attention of physicians of every age, and of young people undergoing the challenges and complexities of growing up:

"Internal discipline is the force that duty exercises to prevent laxness in assuming responsibility. If I may be permitted the anachronism, it is the voice of conscience that tends to be scorned by the immature of all age groups. Conscience concentrates on the ultimate goal and ignores the immediate inconvenience. It makes one execute carefully the boring, the unexciting tasks of education and of life, with the realization that they are stepping stones to higher points that will be exciting. . . . We should not seek a neurotic perfectionism, but when we have thoughtfully established a sound standard it should rigorously be enforced upon ourselves and it should be expected of others.

"A physician can be conscientious two ways: first, scientifically, by ignoring no discoverable detail of his patient's physical and mental status; second, humanistically, by pursuing the course of kindness, compassion, tolerance and understanding. The latter duty takes time and may easily be neglected in a busy life.

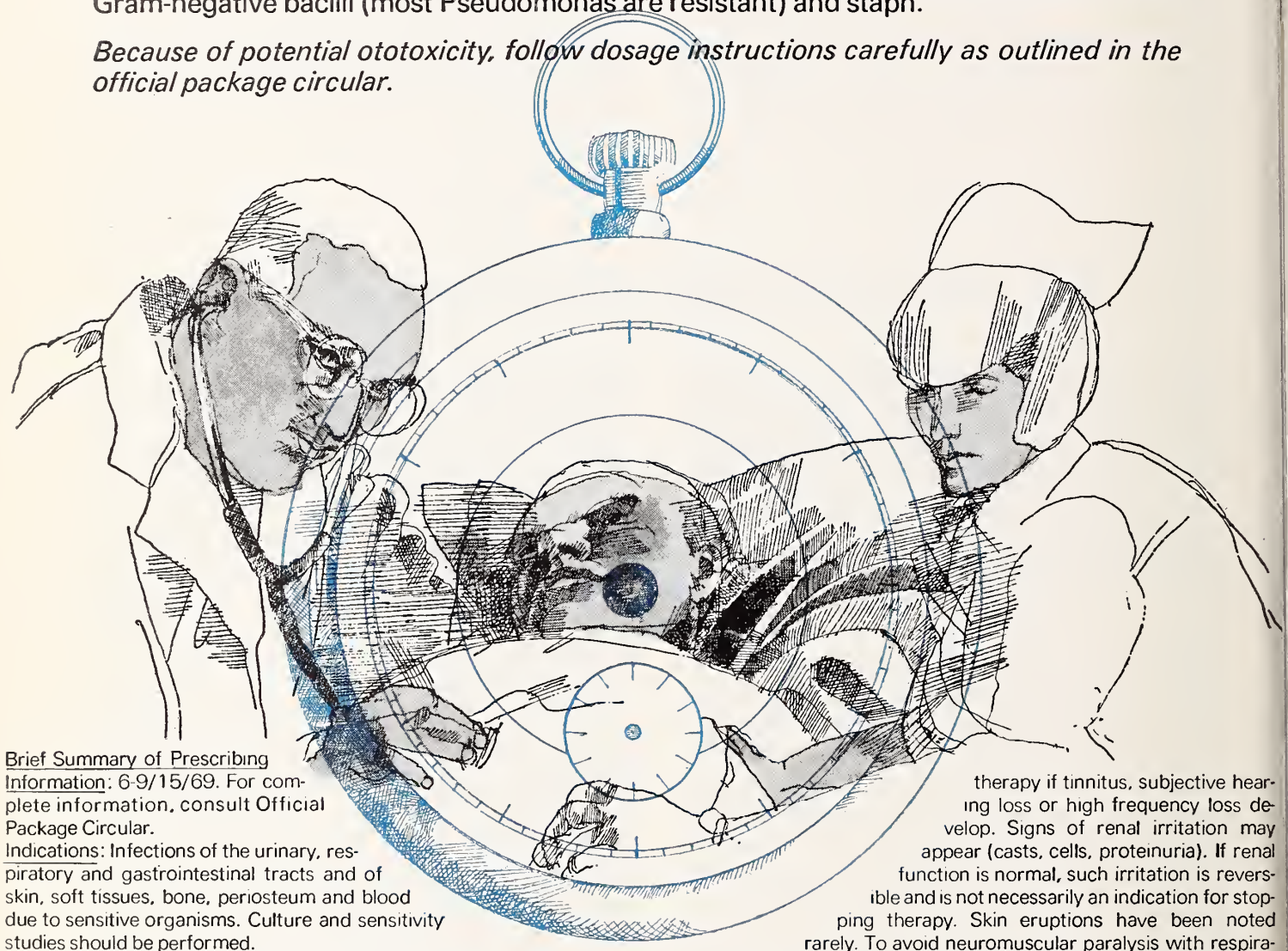
"In our teaching of medicine, we must add to the two basic goals, namely, that of imparting knowledge and of inculcating an intellectual critical insight, another essential ingredient —a disciplined sense of responsibility. The more *internal* discipline is exercised along the way, the less external discipline will be required. We must not yield to youthful importunities to make everything easy and exciting. We must insist that the road is hard and often uninteresting, but that the way is always UP."

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Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.

Warnings: Since the drug is excreted almost entirely by glomerular filtration, renal malfunction can cause abnormally high serum levels of kanamycin which may prove ototoxic. Assess renal function periodically, both before and during therapy. Renal dysfunction or pre-renal azotemia sharply increase the risk of ototoxicity and permanent deafness. In such cases decrease the size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. In older patients and patients receiving a total dose in excess of 15 Grams, watch carefully for signs of ototoxicity.

Precautions: If mycotic or bacterial superinfection occurs, discontinue kanamycin and initiate appropriate therapy. Cumulative ototoxic effects may be produced by concurrent or consecutive use of other ototoxic drugs. High doses may cause irritation at injection sites. The drug *should not* be physically mixed with other antimicrobials.

Adverse Reactions: Severe irreversible hearing loss may occur. Stop therapy if tinnitus, subjective hearing loss or high frequency loss develop. Signs of renal irritation may appear (casts, cells, proteinuria). If renal function is normal, such irritation is reversible and is not necessarily an indication for stopping therapy. Skin eruptions have been noted rarely. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxants is complete.

Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gram daily and should not exceed 1.5 Gram even in the heaviest patients. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. 1.0 Gm. in 3 ml.

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INFORMATION FROM THE
IOWA HEART ASSOCIATION

Newer Concepts of the Evaluation of Cardiac Function

WILLIAM W. PARMLEY, M.D. and
EDMUND H. SONNENBLICK, M.D.

In dealing with the diseased heart, the clinician must make two important judgments. First, the underlying cause of the disease and associated anatomic defects must be determined, and second, the functional consequences of the lesion must be assessed. Although this latter judgment can often be made by a careful history and physical examination, or by imposing a stress such as mild exercise, it is often necessary to make more precise physiologic measurements of cardiac function, which are best obtained during diagnostic cardiac catheterization. This article will briefly discuss some aspects of the cardiac evaluation obtained during catheterization which deal both with the function of the heart as a pump and with the contractile properties of the heart muscle itself. In particular, it is necessary to evaluate to what extent an anatomically correctable defect is causing abnormal loading and "pump" failure and to what degree a depression of cardiac muscle function itself has occurred.

The primary function of the heart is to maintain an adequate cardiac output appropriate to the changing energy requirements of the body. The cardiac output, which is determined by peripheral metabolic needs and return of venous blood, is the product of heart rate and stroke volume. The stroke volume of the ventricle, in turn, is influenced by three factors: (1) the preload or end-diastolic volume, (2) the afterload or pressure level which must be reached in order to eject blood into the aorta, and (3) the contractile state or "vigor of contraction" of the heart muscle.

The stroke volume of the heart is adjusted *beat to beat* by changes in preload or end diastolic volume. Thus as the filling pressure and diastolic volume of the ventricle are augmented, the stroke volume increases, while the fraction of blood ejected by the ventricle remains relatively constant. This increase in stroke volume resulting from increments in end diastolic is known as Starling's law of the heart, and is a primary mechanism whereby cardiac output is altered on a beat to beat basis.

The second factor which influences stroke volume is the afterload. For example, from the same end diastolic volume, a marked increase in aortic pressure will reduce stroke volume, while a decrease in aortic pressure will increase stroke volume. The reduction in stroke volume in a given beat due to an increased afterload, leaves blood behind in the ventricle so that subsequent end diastolic volume will be larger. With this increase in end diastolic volume, the stroke volume will go up and output will be restored.

The third factor which influences stroke volume is a change in the contractile state of the heart muscle. The contractile state, or contractility of the heart, reflects the vigor of contraction and is characterized by the speed and extent of contraction. Normally the contractility of the heart is increased by norepinephrine which is released re- is a change in the contractile state of the heart or from the adrenal glands and is carried by the blood stream to the heart. The increase in the extent of muscle shortening (which accompanies an increase in contractility) is manifest by an increase in stroke volume at the same end diastolic volume. Thus the fraction of blood ejected from the ventricle during each systole is augmented by an increase in the contractile state of the heart muscle.

In disease states, pump performance and muscle function may not be deranged simultaneously. Thus, in severe aortic stenosis, the imposed afterload may be of such a magnitude that pump performance is impaired despite relatively normal muscle function. Similarly in the presence of massive intracardiac or peripheral arterio-venous shunting of blood and markedly elevated cardiac outputs, congestive failure with massive fluid accumulation may ensue, although underlying myocardial function may be normal. It is essential to distinguish failure due to abnormal loading of the heart from that resulting from depression of muscle function per se.

The function of the heart muscle itself may best be analyzed in terms of the relationship between force development in the wall of the heart and the velocity of muscle shortening. This "force-velocity" relation is the most fundamental mechanical relationship of heart muscle and can be calculated from pressure and volume measurements ob-

These authors are associated with Cardiovascular Division, Peter Bent Brigham Hospital and Harvard Medical School, Boston, Massachusetts.

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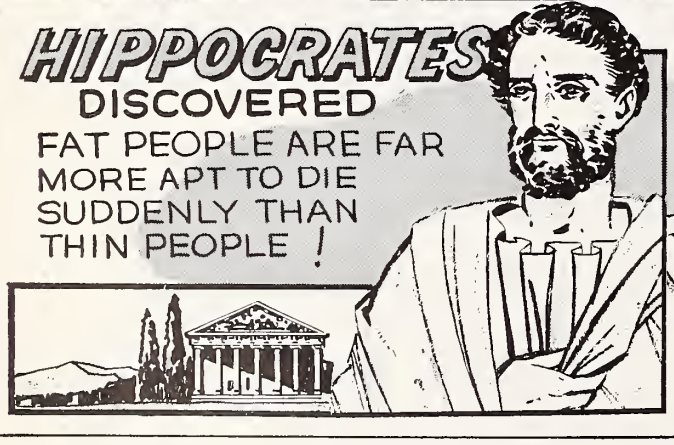
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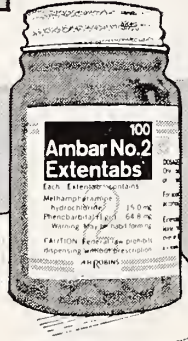
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tained during catheterization. Although this can not be routinely measured at present, current experimental studies suggest that it may become an integral part of future diagnostic catheterization studies. The value of this approach is that it provides a more precise measurement of muscle function aside from overall pump function of the heart which may be influenced by valvular defects or abnormal shunting.

Although a consideration of the above factors allows one to describe cardiac function as a whole, it has recently become clear that localized areas of heart muscle have altered function, particularly in patients with coronary artery disease. With cine ventriculograms obtained by the injection of radio-opaque dye into the left ventricle, regional abnormalities of contraction may be recognized. These include areas of the heart wall which do not move at all (akinesis), areas which contract poorly (hypokinesis), and areas which expand rather than contract (dyskinesis). In addition it is also clear that asynchrony of contraction of the entire heart may also influence cardiac function adversely.

Recent studies have also demonstrated that resting measurements of pump function during cardiac catheterization may be essentially normal in the face of considerable disease of the myocardium. Thus it becomes important to elicit abnormal function by stressing the heart. This is commonly done by having the patient perform supine bicycle exercise, by the intravenous administration of a catecholamine such as Isuprel, or by increasing the heart rate with electrical pacing. Furthermore, abnormal function may also be elicited by increasing the afterload with angiotensin which increases arterial pressure but does not appreciably affect the contractile state of the heart itself. In patients with coronary artery disease, stress tests of the heart have been particularly useful in eliciting regional metabolic abnormalities (lactate production) as an indicator of regional hypoxia unassociated with angina pectoris. Such functional abnormalities have correlated well with the anatomic demonstration by coronary arteriography of occlusion or stenosis of a major vessel to that area of myocardium. The value of measurements made during stress testing of the heart, therefore, is that abnormalities may be induced which are indicative of limited cardiac reserve even though the function of the heart as a pump may appear normal at rest.

In summary, therefore, the pump function of the heart can be measured in terms of filling pressure (end diastolic volume) and stroke volume, while contraction properties of the heart muscle itself are measured by the "force-velocity" relation of the muscle. Furthermore, regional contraction abnormalities can be evaluated by the use of cine studies of the contracting left ventricle. A combination of the above studies can provide valuable information to the practitioner which is of considerable benefit in both the diagnosis and treatment of clinical heart disease.

Educational Opportunity Program In the College of Medicine

The University of Iowa College of Medicine has consistently encouraged and aided students from families of below average income to apply for admission. In recent years this effort has been extended and expanded. In a flier describing the Educational Opportunity Program in Medicine, the College of Medicine asks: *"Are you a person who has already decided he cannot go to college? Do you believe you probably could not be admitted to medical school? Do you think that you couldn't afford to go to medical school or that you would not be admitted? If so . . . please read this."*

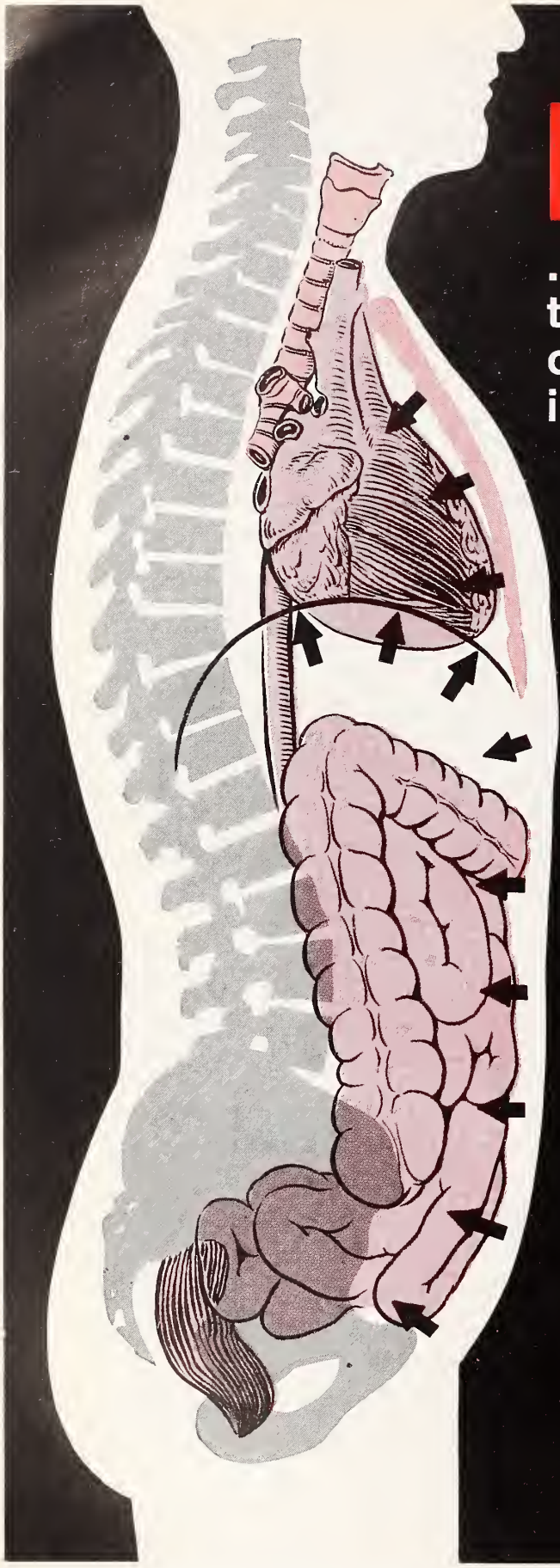
The flier proceeds to answer such questions as "Who can study medicine? How do you seek a career in medicine? How much does it cost? Can you afford it? How do you get into medical school —especially those who qualify for consideration in the College of Medicine's Educational Opportunity Program?"

The real intent of this program is described as follows:

"In general, Iowa does not have a very large proportion of people who have been deprived of the opportunities for a good education—but there are some, and there are many more in other states, and these are the students who would qualify for our Educational Opportunity Program. One way for us to help raise the educational status of our whole country is to help educationally and economically disadvantaged students with the *talent, interest,* and *enthusiasm* for a medical education to obtain the kind of education they need, want and deserve."

There are currently four students enrolled in this program. From a group of about fifteen applicants at least three or more additional students may be admitted.

In this effort help of two kinds is needed. First, the College needs help in finding these young people so they can be given the information and counsel them and their families to develop a long-range plan. Second, the College needs help in building additional scholarship and loan programs especially for these students, many of whom will require virtually complete financial support.



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...to reduce the hemodynamic "bind" of constipation in congestive heart failure

Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



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*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice,* 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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C-12

Iowa Association of Medical Assistants

IAMA State Convention

May 15-17, 1970
Holiday Inn, Waterloo, Iowa

Friday, May 15

5:00-10:00 p.m. REGISTRATION, Main Lobby
8:00 p.m. EXECUTIVE COUNCIL MEETING, Black Hawk Room
8:00 p.m. HOSPITALITY ROOM, Parlor A

Saturday, May 16

8:00-10:30 a.m. REGISTRATION, Main Lobby
8:00-8:30 a.m. CONTINENTAL BREAKFAST, Penthouse, Courtesy of Schlegel Medical Supply
8:30 a.m. HOUSE OF DELEGATES, Parlors C and D
10:15 a.m. COFFEE BREAK, Courtesy of Professional Management

1970 IAMA Convention Committee

Waneta Christensen, Chairman
Molly Plaehn, Co-Chairman
Charlotte Lewis, Program Chairman
Program Committee: Bernice Coverdale, Paula Edwards and Jean Taylor

10:30 a.m. GENERAL ASSEMBLY, Parlors C and D
Invocation—Rev. C. VinWhite, United Presbyterian
Pledge of Allegiance
Welcome—L. L. Zager, M.D., President, Black Hawk County Medical Society
Welcome—Lloyd Turner, Mayor of Waterloo
Welcome—Chamber of Commerce Representative
Welcome—Molly Plaehn, President, Black Hawk Association of Medical Assistants
President's Address—Nancy Hutson, President, IAMA

11:00 a.m. EDUCATIONAL PROGRAM
Speaker: State Senator Charlene Conklin
"Women's Role in Government"

Noon LUNCHEON, Parlors A and B
Invocation—Mrs. Jessie Robinson, Chaplain, Black Hawk Medical Assistants
Speaker—Craig Ellyson, M.D., Waterloo
"Sex Education"

2:15 p.m. EDUCATIONAL PROGRAM, Parlors C and D
Speaker—Harold Fischer, D.D.S., Orthodontist
"Misuse of Drugs and Hippie Movement"

3:15 p.m. COFFEE AND COKE BREAK

3:30-4:00 p.m. DISCUSSION OF NATIONAL MEETING, Des Moines
Nancy Hutson, President, IAMA

4:15-5:15 p.m. TOUR OF RUSSELL HOUSE

6:00-7:00 p.m. COCKTAIL HOUR, Black Hawk Room, Courtesy of Black Hawk County Medical Society

7:00 p.m. BANQUET, Parlors A and B
Invocation—Charlotte Fell
Master of Ceremonies—Norman J. Siderius, M.D.
Speaker—Mr. Jack Bender, Cartoonist. WATERLOO DAILY COURIER
Singing by the Melo-Deere's
Installation of 1970-71 Officers—Jeanne D. Green, Installing Officer
(Balance of evening on your own)

Sunday, May 17

8:30 a.m. CONTINENTAL BREAKFAST, Penthouse, Courtesy of Blue Cross-Blue Shield

9:30 a.m. EDUCATIONAL PROGRAM, Parlors C and D
Speaker—Mrs. Phyllis Singer, WATERLOO DAILY COURIER
"Women Have Brains Too"
Speaker—Mr. Don C. Harting, Loewi & Sons
"Keogh Plan and Small Investments"

Noon LUNCHEON, Parlors A and B
Invocation—Mrs. Bernice Coverdale
Committee Announcements—Colleen Proffitt, President, IAMA
Entertainment
POST-CONVENTION BOARD MEETING, Black Hawk Room

Outstanding Convention

With such an outstanding Convention planned for us, it will be well worth the effort you make to attend. You will meet friends from other areas of the State. For those who are not IAMA members, you are most welcome to attend—join us

in this common effort to do a better job, to be better informed and last, but not least, to enjoy ourselves.

This is an opportunity to meet your officers, to get to know them; they are most anxious to fulfill your wishes, but they do need your help. How many of you have been assigned to a Committee and have not had the slightest idea who the other members were? Did you lose interest and not carry out your obligation? To enjoy a "healthy" and "moving" organization you must participate! Some of our most enthusiastic members are those who reluctantly agreed to "help out," then found what a stimulating experience it was to really be active. We are all accustomed to busy schedules but wouldn't our work be twice as hard if we didn't take advantage of the numerous disposable items now available or the time-saving devices such as copiers, billing machines, etc.?

If you feel you have nothing to gain by attending a Convention, why don't you "come and see"? You will, I am sure, be pleasantly surprised! The Waterloo girls are to be commended for such a fine program and the hours of time they have devoted to the preparations. Let's show them we appreciate what they have done!

SEE YOU IN WATERLOO!

—JEANNE D. GREEN

New Pamphlet Explains AMA to Public

A pamphlet of considerable value to medical societies in their public relations programs has just been released by the American Medical Association. In its 32 pages are outlines of many public services to protect and advance the health of Americans and the world population.

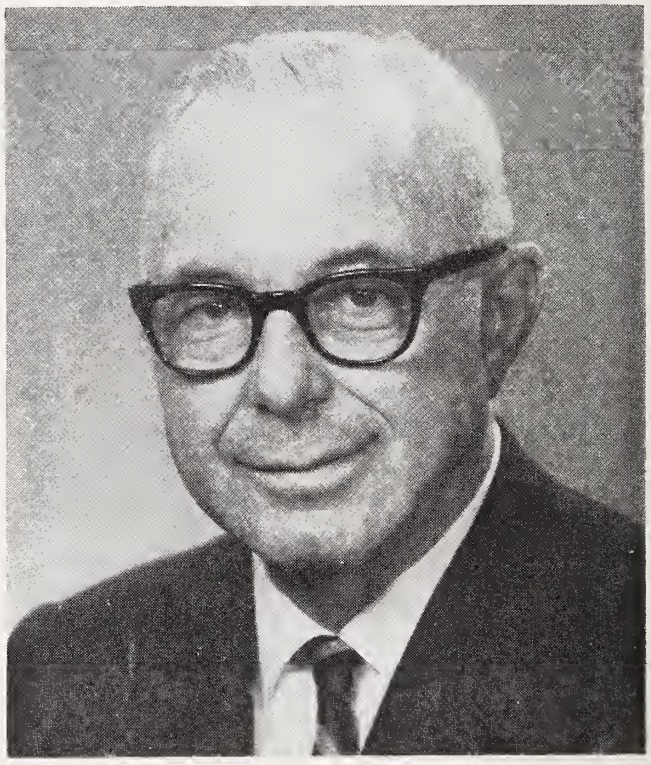
"The American Medical Association . . . Guardian of the Nation's Health Since 1847" summarizes its history and organization. Its real value in contemporary society, however, is in relating the many programs and the cohesive efforts of almost 220,000 member-physicians to promote better health care.

The booklet is intended for distribution to public audiences, but it serves equally well as a "refresher" for physicians and a "primer" for medical students and new society members.

It reviews the AMA's scientific meetings, publications, library and record services, medical student and school scholarships and grants, ethics, drugs, mental health, and health manpower recruitment activities.

The entire booklet is updated, and several new programs are covered: Volunteer Physicians for Viet Nam, the Viet Nam Medical School Project, the new Department of Health Care Organization (to accelerate health care delivery systems), proposing and drafting legislative bills, and the innovative proposals of the AMA Committee on Health Care of the Poor.

Copies of "The American Medical Association . . . Guardian of the Nation's Health Since 1847" are available without cost from Program Services Department, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.



R. H. Flocks, M.D., Honored By Modern Medicine

Rubin H. Flocks, M.D., F.A.A.P., professor and head, department of urology, U. of I. College of Medicine, has received one of the medical profession's most distinguished awards, the MODERN MEDICINE Distinguished Achievement Award for 1970. Dr. Flocks was cited for his significant contributions to the improvement of urologic practice. A Fellow of the American Academy of Pediatrics, Dr. Flocks was president of the American Board of Urology in 1963. He is the current president of the Clinical Society of Genito-Urinary Surgeons, president-elect of the American Society of University Urologists, a member of the Committee on Urology of the National Research Council, and a past member of the National Advisory Cancer Council.

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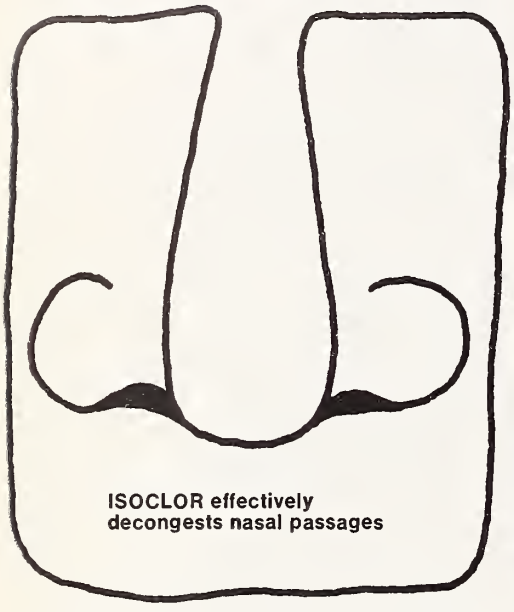
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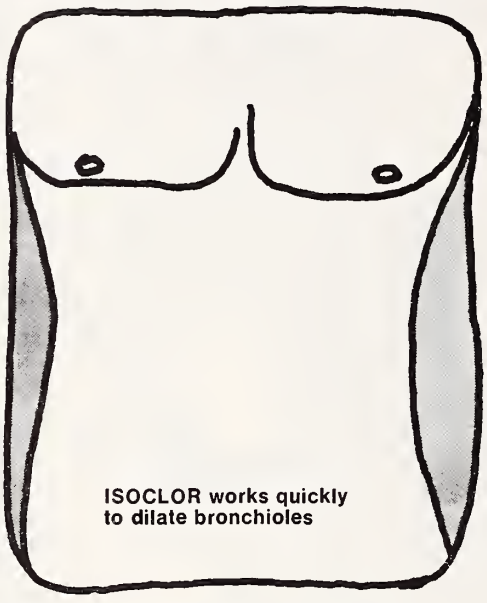
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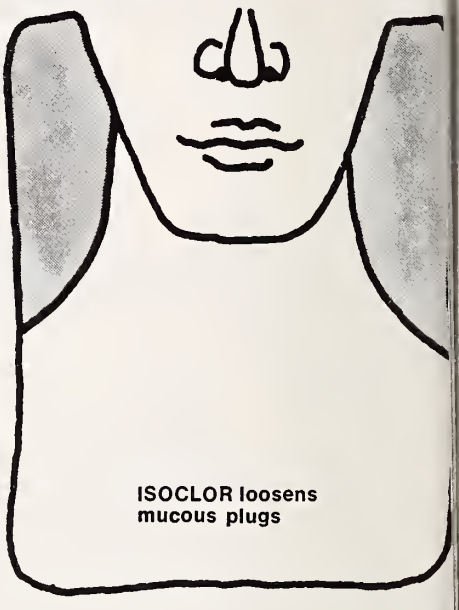
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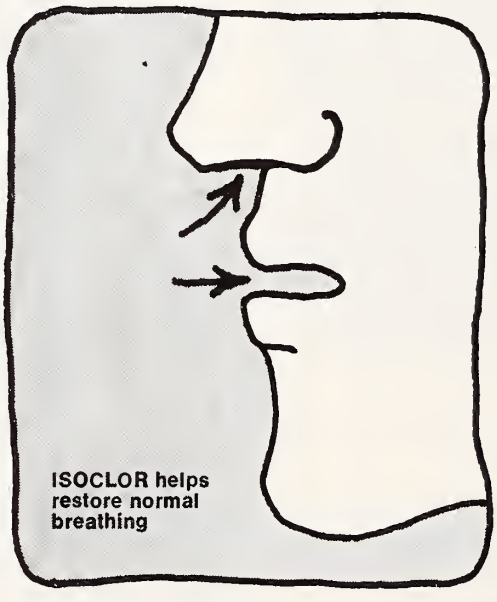
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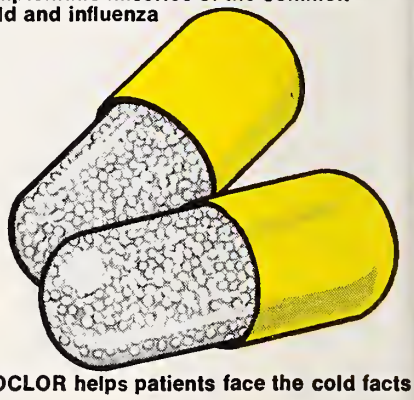


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40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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Alcohol and Home Accidents

The December, 1969 issue of PUBLIC HEALTH REPORTS, published by the U. S. Department of Health, Education and Welfare, included an article entitled "Alcohol Level and Home Accidents." The authors are Henry Wechsler, Ph.D., Elizabeth H. Kasey, M.P.H., Denise Thum, Ph.D., and Harold W. Demone, Jr., Ph.D., of the Medical Foundation, Inc., Boston. The article reports the results of a study of emergency service patients, relating alcohol levels to the reasons for admission. Since this article reports on a little studied area, but one of major importance to physicians and public health workers, it is summarized here. The full article is available as indicated at the end of this summary.

The authors found the relationship between alcohol and accidental injuries and deaths has been investigated frequently. Major research, however, has been limited primarily to traffic or industrial accidents. In an extensive review, Haddon concluded there is a significant relationship between the ingestion of alcohol and the occurrence of traffic accidents. Demone and Kasey reviewed studies of nonmotor vehicle accidents and reported high frequencies of elevated alcohol levels in injured persons. The authors found only two studies in the literature concerning the role of alcohol in home accident injuries.

In a study of 94 home accident victims admitted to the emergency floor of the Boston City Hospital, Kirkpatrick and Taubenhaus obtained inconclusive results in evaluating the relationship between alcohol level and type of injury, length of disability and disposition of the patient.

A report by the Metropolitan Life Insurance Company concluded that alcohol is an important factor in fatal home accidents among young and middle-aged adults, based on a review of the records of "ordinary life insurance" policyholders who died in home accidents in 1964 and 1965. However, involvement of alcohol was usually inferred from descriptions in the records, since objective measures of alcohol level were not available in most instances. Lack of systematic research on such an important public health problem as the role of alcohol consumption in home accidents prompted this study by the Medical Foundation, Inc.

The study was conducted in the emergency service of the Massachusetts General Hospital in Boston. The sample was comprised of patients 16 years of age and older admitted to the hospital's emergency service between October 2, 1966 and September 29, 1967. These patients were interviewed during one 8-hour shift of each 24-hour period for 363 consecutive days. The interviews were conducted during a particular shift on every third day of the study. At least one shift was included on each holiday. This procedure resulted in a one-third sample of all shifts, with an equal distribution of shifts, days of the week, and months of the year. Patients routinely excluded from the study were (1) those admitted for psychiatric reasons, including alcoholics without injury and persons suspected of attempting suicide by ingestion, (2) those who received only postoperative or continuing care in the emergency service, and (3) those with dental problems of nontraumatic origin.

The interview was designed to obtain a description of circumstances surrounding the accident or onset of acute symptoms, as well as relevant biographical material and information concerning drinking behavior. A Breathalyzer reading taken during the interview was used as the primary index of blood alcohol concentration. If a breath sample could not be procured, but a blood sample drawn by the admitting physician was available, the blood sample was used to determine alcohol level. The interviewer also attempted to detect the odor of alcohol on the breath of the patient at the time of admission.

A home accident injury was defined as "any wound or damage to a person occurring in a home or its premises as a result of a chain of events the consequences of which were unintended."

Alcohol levels in home accident victims were compared with those of persons admitted for other reasons. Because of the small number of patients with alcohol levels about 0.05 per cent, Breathalyzer readings were categorized as follows: (a) 0.00 per cent (negative), (b) 0.01 to 0.04 per cent, and (c) 0.05 per cent and over.

The sample on which the statistical analyses consisted of 6,844 patients; 5,622 for whom Breathalyzer readings were available, and 1,222 with other indications of either presence or absence of alcohol.

TABLE 1

BREATHALYZER ALCOHOL LEVEL, BY REASON FOR ADMISSION OF PATIENT

Reason for Admission	Number of Patients	Per Cent Negative Readings	Per Cent Positive Readings 0.01-0.04	Per Cent Positive Readings 0.5 and Over
Accidents	2,801	78.5	11.0	10.5
Home	620	77.7	11.0	11.3
Transportation	404	70.5	12.4	17.1
Occupation	969	84.4	10.6	4.9
Other	808	75.9	10.9	13.2
Nonaccidents	2,633	91.2	6.3	2.6
Circulatory	255	92.2	6.3	1.6
Digestive	481	92.1	5.2	2.7
Symptom	551	90.9	5.8	3.3
Other	1,346	90.7	6.8	2.5
Fights or assaults	188	43.6	17.6	38.8
Total	5,622	83.2	9.0	7.7

Analysis of the data presented in Table 1 revealed a statistically significant relationship between Breathalyzer results and reasons for admission to the emergency service: $x^2 = 546.05$, 16 degrees of freedom, $P<0.001$. To evaluate major trends, several other chi-square analyses were done on the data in this table. Not all these analyses were independent of each other, and this fact should be considered when interpreting the findings. The pattern of results, however, is strikingly clear. An involvement of alcohol in home accidents has been indicated by a systematic large-scale study using objective measures of alcohol level. The authors do indicate some caution must be exercised in interpreting the results.

First, the study is correlational and cannot be viewed as establishing a causal relationship between consumption of alcohol and occurrence of accidental injuries.

Second, the comparison group of nonaccident cases may not have been representative of the community with respect to alcohol level since it consisted of ill persons seeking treatment. Nevertheless, when factors such as general diagnostic grouping, age, sex, marital status and social class were considered, this comparison group still had a strikingly lower alcohol level than the patients with accident injuries. In theory, it would have been preferable to use control respondents selected from residents of the area where the home accident occurred and to have studied them at the same time of day and day of the week as the accident. Such a design however would be difficult to implement and would result in a much higher refusal rate, this biasing the sample.

Finally, the alcohol level of the patient was measured at the time of admission rather than at the time of the accident. Several factors precluded the accurate estimation of alcohol level at the time of the accident. These included the impracticability of obtaining two Breathalyzer readings for each patient to determine individual decay rates. Analyses that controlled for chronology of drinking and delay in obtaining treatment indicated, however, that the relationship between alcohol level and reason for admission was maintained for those patients (1) who reported no consumption of alcohol after the accident or onset of symptoms, and (2) who arrived in the emergency service less than 3 hours after the episode.

The results of statistical analyses, significant at the 0.05 level or beyond, indicated the presence of alcohol on admittance was associated with the reason for admission. Among patients with home accident injuries, 22.3 per cent had a positive Breathalyzer reading. As shown by Breathalyzer tests, the highest involvement of alcohol, 29.5 per cent, was for patients with transportation accident injuries. Less alcohol involvement was indicated for patients with occupation accident injuries, 15.5 per cent, and "other" accident injuries, 24.1 per cent.

A strikingly high involvement of alcohol was found among persons admitted to the emergency service for treatment of injuries from fights or assaults; 56.4 per cent of these had a positive Breathalyzer reading. A uniformly low involvement, 8.9 per cent, was found among patients admitted for nonaccident reasons.

These findings were substantiated when other signs of alcohol involvement were used and were maintained when controls were applied for drinking after the accident or onset of symptoms and for delay between the episode and arrival in the emergency service, as well as for sex, marital status and social class.

Among home accident injuries, statistically significant relationships were found between presence of alcohol and external cause and nature of the resulting injury. Positive readings for alcohol were equally distributed among those injured in falls, collisions and fires, and by cutting or piercing instruments. Patients with head injuries or lacerations more frequently had positive alcohol readings than patients with other types of injuries such as fractures, contusions, sprains or burns.

The study established that a higher proportion of positive alcohol readings occurred among home accident victims and other accident patients than among a comparison group of nonaccident patients admitted to the same hospital emergency service. The findings are consistent and clearcut and implicate alcohol as a factor in home accident injuries as well as in injuries from trans-

portation, occupation (although the findings were less definite here), and other types of accidents and in injuries resulting from fights or assaults.

The article includes detailed information about the various comparisons made and actual statistical results. A full copy may be requested from Dr. Henry Wechsler, The Medical Foundation, Inc., 29 Commonwealth Avenue, Boston, Mass. 02116.

Morbidity Report for Month of February, 1970

Diseases	Feb. 1970	1970 to Date	1969 to Date	Most February Cases Reported From These Counties
Brucellosis	1	3	1	Buena Vista
Chickenpox	783	1,884	1,426	Black Hawk, Des Moines, Johnson, Lee, Linn, Polk
German measles	366	616	515	Black Hawk, Buena Vista, Polk
Gonorrhea	404	750	560	Scattered
Impetigo	56	120	76	Polk
Infectious hepatitis	26	61	79	Pottawattamie, Scott
Infectious mononucleosis	86	145	124	Johnson
Influenza A2	6	12		Johnson
Malaria, imported				
P. vivax	3*	4*	3	Linn, Louisa, Polk
type undetermined	1*	1*	0	Pottawattamie
Measles	21	21	53	Polk
Meningitis				
Aseptic	1	1	0	Cedar
Group B	1	1	0	Linn
Meningococcal	1	1	5	Scott
Mumps	1	1	0	Winnebago
type unspecified	2*	4	2	Johnson, Polk
Mumps	487	823	1,678	Bremer, Pottawattamie, Wapello
Pneumonia	92	162	97	Pottawattamie
Rabies in animals	9	16	20	Scattered
Rheumatic fever	3	7	16	Mitchell, Palo Alto, Plymouth
Salmonellosis				
S. blockley	2	2	1	Linn, Woodbury
S. infantis	1	2	1	Black Hawk
S. typhimurium	1	4	8	Wright
Group B	2	2	3	Polk
Shigellosis				
S. sonnei	7	23	2	Dallas
Streptococcal infections	906	1,612	1,114	Johnson
Syphilis	36	76	105	Scattered
Tuberculosis, active	7	16	25	Scattered

*Delayed

Iowa Thoracic Society Annual Meeting and Medical Program

A half-day medical program will precede the Annual Meeting of the Iowa Thoracic Society, Wednesday, May 6, at the Hotel Savery in Des Moines.

Beginning at 1:00 p.m., the presentations will include:

"Transcatheter Brush & Forceps Biopsy of Lung Lesions," by John J. Fennessy, M.D., Associate Professor, Department of Radiology, University of Chicago College of Medicine;

"Effects of Drugs on the Pulmonary Vascular Bed," by Vincent Shiro Aoki, M.D., Assistant Professor, Departments of Internal Medicine and Pharmacology, The University of Iowa;

"Studies on a Toxic Substance from *Mycobacterium Tuberculosis*," by Irvin S. Snyder, Ph.D., Associate Professor, Department of Microbiology, The University of Iowa, and Mr. Edward V. Savard, Graduate Student and Fellow of the Iowa Thoracic Society; and

"Tuberculosis Revisited," by John E. Kasik, M.D., Associate Professor, Departments of Internal Medicine and Pharmacology, University of Chicago College of Medicine.

George G. Spellman, M.D., Sioux City, president of the Iowa Thoracic Society, invites all Iowa physicians to attend. Spouses are welcome.

Following the scientific program, there will be a hospitality hour at 5:30 p.m. and a dinner at 6:30 p.m. The Society's business meeting and election of officers will follow the dinner.

FIRST SESSION

IMS House of Delegates

Sunday, April 26

will be held at the

Fort Des Moines Hotel

beginning at 9:00 a.m.

★

SECOND SESSION

IMS HOUSE OF DELEGATES

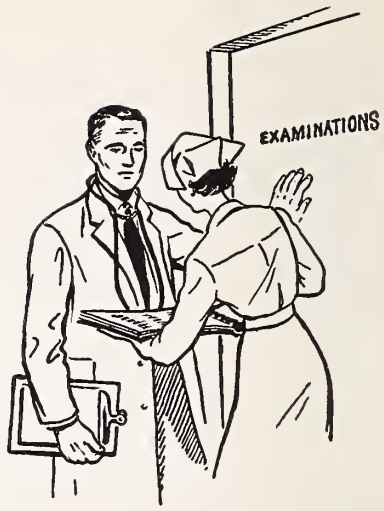
Wednesday, April 29

will be held at the

Savery Hotel

beginning at 8:00 a.m.

THE DOCTOR'S BUSINESS



Take a Good Look at Your Office

LARRY E. LEAVERTON
Des Moines

How does your office look to your patient as he or she enters your reception room? Does the carpet show wear? How about the furniture and accessories? In addition to general appearance, is your furniture and equipment modern and up to date? Your entire office needs a periodic critical inspection to be certain it is arranged, furnished and equipped to present an overall pleasing appearance and for maximum utility.

The location of your office is basic. It should be convenient to both patient and doctor. Commuting time from residence to office and office to hospital should be at a minimum. The office should be planned, arranged and equipped for efficiency.

The first impression is provided by the reception room. This area should be comfortably and tastefully furnished. Your specialty will have a bearing on the manner and general decor. If you feel you need assistance, call on a professional decorator for advice.

The next area you see is the business office. Do you have modern serviceable time-saving equipment to handle efficiently the increased volume of patients? Some physicians will purchase the latest in medical or business equipment and then expect their medical secretaries to give top performance in poorly arranged business offices. Does the secretary have enough counter space and a posture chair to provide comfort and ease fatigue?

Most new pieces of business equipment are of the time-saving variety—such as electric typewriters and adding machines, inter-com systems, dictating equipment, copy machines, files, mailing equipment and touch-tone telephones. Not all of these items are necessary for every medical office. Before a piece of equipment is purchased its purpose and use must be clearly defined. For example, do you really need new file cabinets or do the present cabinets need cleaning out? Would shelf files give you the additional space needed? What is the main purpose of the copy equipment you may be considering? How much will it be used? Do you have enough mail to justify mailing equipment? There are many excellent dictating machines on the market but some doctors still have not tried them. Good dictating equipment can be a great time-saver. Determine the need before purchasing office equipment.

With all items of office equipment, the reliability and service capability of the seller are very important. In much of the office equipment industry, competition has reduced prices and has brought about a broad selection of models. Consult a reliable dealer in office equipment, and ask the opinion of your employees who will be using the equipment.

The examination or treatment rooms should contain duplicate equipment so they can be used interchangeably during peak periods. The number of such rooms will depend upon your type of practice; if you find yourself being slowed by lack of facilities, additional space may be necessary.

The consultation office is a matter of personal preference for the doctor. In our opinion, a doctor should have a pleasant comfortable place for a consultation, a place to relax, read or do paperwork. If you are a collector of journals and articles to be read "tomorrow" a side or rear cabinet or credenza will keep these out of sight and present a neater appearance. In addition to the consultation office, many doctors like the convenience of a small desk or writing space in each examination or treatment room.

Storage space, laboratory and convenient restroom facilities complete physical make up of your office. Accumulation of inactive records that must be retained, plus the increasing use of disposable supplies, make storage space necessary. If a storage room or closet is not available overhead cabinets in the business office, lab and exam rooms will serve well.

Many people will make an initial judgment of a physician on the appearance, quality and efficiency of his office equipment and furnishings.

Take a good look at it in the eyes of the patient. Would you be impressed?

Mr. Leaverton has been associated with Professional Management Midwest since 1949. He is a partner in the firm, and is director of its Research and Development Department.

Woman's Auxiliary News

From the President's Desk

It is with a sense of regret that I begin my final contribution to the WOMAN'S AUXILIARY NEWS as your President. This has been a strenuous but most rewarding year. I shall always treasure the friends I have made during my term of office.

One of the most enjoyable duties, if you care to call it a duty, is and has been the opportunity to visit county auxiliaries over the State.

Our Board meetings have been a real joy. The problems and matters which have come before the Board have produced lively discussion at times, but the decisions have been made amicably.

My visits to out of state auxiliary meetings have been particularly fruitful and have further impressed upon my mind the fact that the Auxiliary is composed universally of dedicated and altruistic women. Certainly we are making a contribution nationally and locally in support of the American Medical Association and its component societies.

I feel it is essential that current Auxiliary members extend a welcoming and helpful hand to young doctors' wives who come to their communities. We must instill in these newcomers the desire to belong to and to promote the Auxiliary. As in all organized society, the hope for the Auxiliary lies with properly inspired youth.

Auxiliary members can work together, organize a county auxiliary, do constructive community work and support medicine generally even though their spouses may not necessarily be coworkers. It is important that we remember the Auxiliary's prime Mission is to support organized medicine. The best way we can do this is by organization. United we can carry forward a community service and public relations program which will be a credit both to ourselves and to our sponsor, the medical profession.

My eternal gratitude goes to the officers, chairmen, councilors, committee members and others who have functioned so admirably this year and who have worked so diligently and cooperatively in carrying on the Auxiliary's business. I am also very grateful to the officers of the Iowa Medical Society, and to Mrs. Hazel Lammey, Administrative Secretary of the Auxiliary, and IMS staff. I would be remiss if I did not express my thanks to our most helpful past presidents.

My final admonition is "All roads lead to Des Moines" April 26-28 for the 1970 Annual Meeting.

—JEANNE COUGHLAN (MRS. D. W.)

Impossible Dreams

Unreachable goals? Do you know a student interested in a health-related career who may not be able to reach that goal because of insufficient funds? Low-interest loans to students interested in nursing, medical and radiologic technology, inhalation, physical and occupational therapy and other *approved* training programs are available through the Auxiliary's Health Education Loan Fund.

If your Auxiliary needs information on the loan fund, or does not have application forms, contact Mrs. William R. Bliss, Chairman, HELF, 2115 Hughes Avenue, Ames, Iowa 50010, or your Woman's Auxiliary office, 1001 Grand Avenue, West Des Moines, Iowa 50265.

Applications for loans should reach Mrs. Bliss by June 1, so your student will be considered while funds are still available.

WOMAN'S AUXILIARY
to the
IOWA MEDICAL SOCIETY

★

1970 Annual Meeting
April 26 to 28

★

HOTEL KIRKWOOD
Des Moines

Around the Hawkeye State

Black Hawk County

The Black Hawk Medical Auxiliary held its annual Medicine Ball at Electric Park in Waterloo, February 7, with 400 persons present. Over $1,000 was cleared and will be donated to a medical charity; several worthy projects are being considered.

The regular February meeting was February 17 at Black's Tea Room, with 81 in attendance for brunch and a style show. The Dental and Pharmaceutical Auxiliaries were entertained.

Polk County

The annual Health Careers Tea was March 6 at the Methodist School of Nursing. Health Career pins were given to students who earned them through activities established by the Health Career Clubs in the county.

Dr. Robert Schulze spoke and showed slides about his trip to Malaysia with the Medico program under CARE. Mrs. Dennis D. Wilson was in charge of arrangements.

The Polk County Woman's Auxiliary honored Mrs. Martha Canfield February 13, as the winner of its "Volunteer Health Service Award." Her name was presented for consideration by the State Auxiliary.

Doctor's Day was observed on March 30 this year. Auxiliary members made personal visits to each of the retired and/or ill doctors in the county.

Scott County

The Scott County Auxiliary has achieved success once again with its DOCTOR-TO-DOCTOR Christmas Greeting Project. This original attractive greeting card appeals to more persons each year. Kay Kehoe reports in "The Scope" of Scott County Medical Auxiliary that, "when all funds are in, the project will have netted a mammoth $1,323.78." The proceeds from this project are used to support a local community health program.

Hilda Anrode, with help from Yvonne Boone, is preparing table decorations for the annual AVA PREACHER MEMORIAL DINNER to be held in Davenport on April 19. Ava Preacher is remembered not only in Scott County, but by many in other parts of the State for her interest and support of the Auxiliary. She was a member of the Board of Directors of the WA to the IMS until the time of her death.

As Area Chairman for the State Annual Meeting April 26-28, Kathy Weiss has enlisted the Scott County Auxiliary to help plan and prepare interesting table decorations to be used at the several luncheons.

Give Blood! Give Life!

Many communities have been experiencing a critically low blood supply, and the National Auxiliary is urging we do something about it by becoming active in a blood donor campaign.

If your Auxiliary has not been active in this project perhaps this is where you can be of substantial help to your community. First, however, consult your medical society and ask for guidance. After studying the community blood banking system and procurement procedures, an educational program can be put into action. Knowledgeable Auxiliary members can then inform other community leaders and groups and urge them to participate.

If your community blood bank is already receiving extensive volunteer assistance, the Auxiliary should consider supplementing that effort, rather than embarking on an independent program. After you have received approval of your local medical society, contact the medical director of the blood bank supplying the community. If your area is covered by the Red Cross, communicate with the director of your Regional Red Cross Blood Center. Help is needed in most locations . . . your efforts will be greatly appreciated.

Some blood banks may not be experiencing any shortage, others experiencing a shortage may be purchasing blood from professional donors or from remotely located commercial blood banks. Use of these sources not only increases the cost of blood to the community but exposes it to the possibility that the blood product may not be of the same high quality as that obtained from regular voluntary local donors.

The real problem turns on the failure to get sufficient numbers of replacements from friends and relatives of those who require blood. The Auxiliary can help here by urging their husbands to organize and then helping to organize, in cooperation with the local blood banks, lists of those who have not replaced blood. Possibly the Auxiliary could develop small brochures with the assistance of the medical directors of the blood banks. These brochures could speak on behalf of the physician and urge the replacement of blood; they could be included with the statements the physician sends out each month. Perhaps follow-up calls could be made to urge persons who have received blood to replace it at a local blood bank; help could be provided in arranging an appointment.

By becoming a regular blood donor, and by urging others to do so, wives of physicians will be giving and sustaining life. Members unable to give blood can serve in other ways. They can recruit donors, do clerical work or participate in other important areas to make the program a success.

The Scott County Medical Society Blood Bank in Davenport has as its medical director, W. S. Pheteplace, M.D., who is also chairman of the IMS Committee on Blood Banking. He has provided us with much of the preceding information; he has also volunteered the services of consultants for any group wishing to set up a family plan donor club within its local blood bank. Such a plan, which provides a donor assurance program, has been in operation in Scott County since 1956, and the county auxiliary assisted with the establishment of the program.

You Can Participate

Regardless of the size of your Auxiliary, you can do several of the following:

1. Be able to explain the viewpoint of the medical profession in its efforts to work in the public interest.
2. Be a source for health materials, exhibits, films, pamphlets and speakers; know what is available to you through the medical associations and the Auxiliary central office.
3. Serve your community by aiding health and rehabilitation programs and hospitals.
4. Support the American Medical Association Education & Research Foundation. Interpret to friends the importance of high standards for medical schools.
5. Promote safety in your home and on the highway.
6. Give a TODAY'S HEALTH gift subscription to a student, teacher or beauty shop.
7. *Help recruit* young men and women for training in one of the professions allied to medicine. Support your Health Education Loan Fund.
8. Prepare your home for civil defense emergencies.
9. Support the political party of your choice.
10. Pay dues to help carry on Auxiliary activities.

April

Beautiful April's come at last
The leaves are green and new.
Winter days are in the past
The gray skies turned to blue.
The wind blows warm this time of year
The sun bursts forth its rays.
And, even though May is drawing near
I savor April's lovely days.

—CONNIE COUGHLAN



A February Highlight

Wives of Iowa's legislators and other top state officials were honored by the Auxiliary at a February 10 continental breakfast at IMS Headquarters. The morning highlight was a discussion of medicine in Europe by J. H. Sunderbruch, M.D., IMS president-elect.

Pictured above are those who planned the event. They are, left to right, Mrs. D. W. Coughlan, Des Moines, Auxiliary president; Mrs. L. R. Cornish, Indianola, co-chairman; Mrs. J. R. Schutter, Algona, state legislative chairman; Mrs. F. M. Burgeson, Des Moines, president, Polk County Auxiliary, and co-hostess; Mrs. C. J. Peisen, Des Moines, co-chairman; and Mrs. C. A. Trueblood, Indianola, general chairman (seated).

Shown below are Mrs. L. H. Prewitt, Ottumwa, president-elect, Woman's Auxiliary to the IMS; Mrs. D. W. Coughlan; and Mrs. Robert D. Ray, wife of the Governor of Iowa.



I Believe

I BELIEVE in the material I am handing out . . . in the organization I am working for . . . and in my ability to get results.

I BELIEVE that honest material can be passed out to honest men . . . by honest methods.

I BELIEVE in working . . . not weeping . . . in boosting . . . not knocking . . . and in the pleasure of my job.

I BELIEVE that a man gets what he goes after . . . that one deed done today is worth two deeds tomorrow . . . and that no man is down and out until he has lost faith in himself.

I BELIEVE in today and the work I am doing . . . in tomorrow and the work I hope to do . . . and in the sure reward which the future holds.

I BELIEVE in courtesy . . . in kindness . . . in generosity . . . in good cheer . . . in friendship . . . and in honest competition.

I BELIEVE that there is something doing . . . somewhere . . . for every man ready to do it.

I BELIEVE that I am ready . . . RIGHT NOW!

ARE YOU?

Children and Youth

Have you seen "The Mechanical Smoker," a device which dramatizes the truth about smoking?

It is an intriguing, exciting educational tool which demonstrates the dangers of cigarette smoking. The "Smoker" was created by a medical doctor to emphasize the causes of pulmonary cigarette disease in a way that even young children can understand, hopefully to reduce the incidence of "pupil" smokers.

The "Smoker" inhales into a plastic bag the tars and nicotine from a cigarette and deposits them on a "Mini-Lung"; this corresponds with the actual entry of these elements in the lungs of a smoker.

The "Mechanical Smoker" may be purchased by your Auxiliary for use in school demonstrations. Or you may write Mrs. James D. Kimball, 1015 Lake Shore Drive, Osceola, Iowa 50213, Chairman of the Children and Youth Committee, to request the one which has been purchased for the Committee to use. Mrs. Kimball reports excellent reception in the areas she has demonstrated the "Smoker." She also has follow-up materials available for you. Write her today!

Former President Dies

Mrs. Frank Gastineau, President of the Woman's Auxiliary to the American Medical Association in 1959-1960, died February 13, in Indianapolis. At the time of her death, she was the only woman on the Board of Directors of the American Political Action Committee (AMPAC) and served as its secretary-treasurer.

Many Iowa Auxiliary members will remember Mrs. Gastineau; she was our national guest at the 1960 Annual Meeting of the WA to IMS.

National Convention

The 1970 Convention of the Woman's Auxiliary to the American Medical Association will be held in Chicago, June 21-25, with headquarters at the Drake Hotel.

A reservation form appears in the March issue of MD'S WIFE. Rooms will be available prior to and following the convention at the rates shown in that issue for those who wish to spend more time in Chicago.

A very interesting and entertaining program for pre-teens and teenagers of Auxiliary and AMA members is being planned by *Gulliver's Trails* with the Teenage Committee. Complete details later.

Participation

The Annual Meetings are the practical way
To voice your opinion and to have your say.
Decisions are reached; and in your heart
You have found the truth by doing your part.

—Anonymous

AMA-ERF Fund Raising Projects

Note Paper
Playing Cards

Mrs. R. M. Perkins
125 East Rusholme Street
Davenport 52803

or

Woman's Auxiliary Office
1001 Grand Avenue
West Des Moines 50265

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. D. W. Coughlan, 1435 Park Avenue, Des Moines 50315
President-Elect—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501
Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312
Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228
Editor of THE NEWS—Mrs. D. A. Mater, 302 S. 4th Street, Knoxville 50138
Assistant Editor—Mrs. R. J. Foley, 1025-16th Street, West Des Moines 50265



Personals



Dr. Larry H. Boeke, of West Union, has been elected to membership in the American Academy of General Practice.

Drs. A. S. Norris, professor of psychiatry at the U. of I., and **William G. Stone**, a Waterloo psychiatrist and medical director of the Black Hawk County Mental Health Center, participated in a symposium on the drug scene at the U. of I. March 3 to 5. The symposium was sponsored by campus ministers, university students and staff, public school administrators and community leaders.

Dr. Robert E. Votteler, of the Mental Health Clinic in Marshalltown, spoke to the Child Study Group of the United Methodist Church in Marshalltown on February 11. His topic was "How to Better Your Child's Personality."

A new Explorer Scout Post has been organized in Waterloo under the Sponsorship of the Black Hawk County Medical Society. The co-ed Scout program will provide young men and women the opportunity to learn about and explore careers in the field of medicine. Three Waterloo physicians are participating in the program: **Dr. F. Harold Entz**, represents the Black Hawk County Medical Society as the institutional representative; **Dr. Heinz S. Jacobi** is the post advisor; and **Dr. Gilbert Clark** is the committee chairman.

Dr. Walter J. Kopsa, of Tipton, was re-elected chairman of the Cedar County Board of Health in January.

Dr. Richard D. Wells, of Waterloo, spoke at a Lenten service on February 11 at the community's First Presbyterian Church. Dr. Wells discussed "Operation Bridgeway," a program instituted by the school system to help unite the school district.

Dr. G. William Jones, Des Moines internist, has been elected president of the board of directors of Day Care Service, Inc., an educational program for children of working mothers.

Dr. Ross C. King, of Clinton, was guest speaker recently at the Hospital Chapter meeting of Clinton Women of the Moose.

Drs. Don O. Newland, Des Moines obstetrician and gynecologist, **Robert M. Kretzschmar**, associate professor in the Department of Obstetrics and Gynecology at the U. of I., and **L. W. Porter**, of Indianola, participated in a February symposium on human sexuality at Simpson College in Indianola.

The Tama County Nurses Association had as its February speaker, **Dr. C. W. Maplethorpe**, of Toledo. He discussed a variety of subjects, including: cardiac massage as a life-saving procedure on a patient with cardiac fibrillation; the changing picture of medical service in rural Iowa; the new coordination program among Marshalltown hospitals; and the current rubella eradication program in Iowa.

Dr. J. H. Spearing, of Harlan, has been elected president of the Shelby County Medical Society for 1970. Other officers are: **Dr. L. V. Larsen**, vice-president, and **Dr. R. D. Harris**, secretary-treasurer. Both Dr. Larsen and Dr. Harris reside in Harlan.

Dr. James F. Stiles, of Cedar Rapids, was guest speaker at the February meeting of the Linn County Association of Medical Assistants. His topic was medical law.

Dr. Thomas L. Coriden, of Sioux City, participated in a panel discussion on venereal disease

on February 19. The discussion was sponsored by Monahan Post 64, American Legion, and occurred at the Elks Lodge in Sioux City. Dr. Coriden is the Woodbury County medical examiner.

The Pottawattamie-Mills County Medical Society has contributed $1,000 to the Health Planning Council of the Midlands. The Council is composed of business executives, prominent citizens and doctors from counties in southwest Iowa and eastern Nebraska. **Dr. James Knott**, of Council Bluffs, president of the county society, reports "the purpose of the council is to correlate and implement medical facilities in southwest Iowa and eastern Nebraska." The Council Bluffs representative on the Council is **Dr. Irving Hanssmann.**

Dr. E. K. Vaubel, of Estherville, recently completed a postgraduate course on coronary care at the U. of I. Coronary care monitoring equipment is to be installed in the near future at the Holy Family Hospital in Estherville.

Dr. Newell Kelley, of Des Moines, retires as medical director of The Bankers Life April 1. Dr. Kelley will be succeeded by **Dr. Fred Dinkler**, also of Des Moines. Dr. Kelley has served on the medical staff of the Des Moines-based insurance company since 1955; he has been medical director since 1966. He plans to enter private practice in Millbridge, Maine.

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Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.
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Dr. Mark D. Ravreby has been elected chief of staff at Northwest Hospital in Des Moines. Other new officers are **Dr. Don C. Green**, vice-president, and **Dr. Charles Johnson**, secretary-treasurer. New chiefs of service are: **Dr. Byron Augspurger**, radiology; **Dr. Ronald Villella**, pathology; **Dr. James Caterine**, surgery; **Dr. James Bell**, general practice; **Dr. Ravreby**, internal medicine; **Dr. Mark Thoman**, pediatrics; **Dr. Rafael Ortiz**, anesthesia, and **Dr. Albert Mintzer**, obstetrics and gynecology. These physicians practice in Des Moines or the surrounding suburban area.

Drs. William E. Connor and **Harold P. Schedl**, professors of internal medicine at the U. of I., have been named co-editors of the JOURNAL OF LABORATORY AND CLINICAL MEDICINE. **Dr. Francois Abboud**, also a professor of internal medicine at the U. of I., has been named associate editor of this journal, which is the official publication of the Central Society for Clinical Research.

Dr. Paul Ferguson, of Lake City, spoke in February at a quarterly meeting of the Council for Exceptional Children in Denison. His topic was "Early Identification of the Mentally Retarded and Attendant Problems for the Physician, the Family and the Educator."

Dr. Arthur P. Echternacht, Fort Dodge radiologist, is now providing Algona's St. Ann Hospital with two days of special x-ray coverage. The increased service started February 2. Since 1950 Dr. Echternacht has been serving the Algona hospital one day a week.

Dr. Stanley W. Greenwald, of Iowa City, will be installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting, April 12-18, in New York City.

Representatives from 15 east central Iowa county chapters of the American Cancer Society held a planning session in Cedar Rapids on February 11. **Dr. R. E. Weland**, of Cedar Rapids, chairman of the Linn County chapter, explained the meeting was "to review plans for an extensive education and fund-raising effort in April which will involve more than 45,000 Iowa volunteers." County chapters involved were Jones, Benton, Black

Hawk, Cedar, Clayton, Clinton, Delaware, Dubuque, Iowa, Jackson, Linn, Muscatine, Scott and Tama.

Dr. T. E. Kane, of Boone, was guest speaker at a February 19 meeting of the Home Life Department of the Boone Woman's Club. Subject of Dr. Kane's talk was "The Wonders of Today's Medicine."

Dr. Douglas Johnson, former psychiatric director at the Maximum Security Hospital at Oakdale, has entered private practice at Dubuque. He will be associated with **Dr. Richard Lee**, a Dubuque psychiatrist.

Dr. R. L. Bartley, of Audubon, was recognized on February 18 at a special Court of Honor for his contribution to the Scouting program in Audubon. A silver serving tray with the Scout emblem engraved on it was presented to Dr. Bartley.

Drs. Irving J. Hanssmann and **M. P. Margules**, both of Council Bluffs, were guest speakers at a February 25 workshop on "Hospital and Home Care of Stroke Patients." The workshop was sponsored by the Iowa Heart Association and was was held at the St. John's Lutheran Church in Council Bluffs. It was designed to help staff personnel of hospitals, nursing homes, and others who provide day-to-day care to stroke patients.

Dr. William Bennett, of Marion, was a recent guest of the Seventh 105mm Howitzer Battery, Fourth Marine Division, of Waterloo, during its annual training period at Camp Pendleton, California. Dr. Bennett, who became interested in medicine while in the Marine Corps, took a two-week vacation from his practice to accompany the marines as the unit's photographer. Permission was obtained from Marine Corps headquarters for Dr. Bennett to accompany the unit at his own expense. He first saw Camp Pendleton as a marine private during training in 1950. A veteran of Korea's "Frozen Chosen" campaign, Dr. Bennett was wounded in the left arm by machine-gun fire and spent nine months in the Naval Hospital, Oakland, California. It was during his recovery, while working with the hospital staff, that Dr. Bennett decided to study medicine.

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Dr. Walter A. Anneberg, a member of the Carroll Rotary Club for 46 years, was honored February 23 at the Club's 49th anniversary dinner. Dr. Anneberg, who joined the club in 1924, three years after it was chartered, was presented a silver medallion commemorating Rotary's founder, the late **Paul Harris.** Dr. Anneberg has been an active participant in Rotary programs and projects throughout the years, and has served as president and chairman of the Rotary Foundation program. At the anniversary dinner, **Dr. Paul D. Anneberg,** also of Carroll, traced the history of Rotary from its founding in Chicago in 1905.

Dr. Paul From, Des Moines cardiologist, was a guest of Farm Editor **Herb Plambeck,** on the February 21 WHO Farm Hour. Dr. From discussed the Comprehensive Stroke Program of the Iowa Heart Association, which was founded in north Iowa and is presently being expanded into other areas of the state by the IHA in conjunction with the Iowa Regional Medical Program. Dr. From is the chairman of the Capital Stroke Program and is active in the Demonstration Stroke Unit at Mercy Hospital in Des Moines.

The 1969 Centerville Community College yearbook, THE FALCON, has been dedicated to **Dr. M. G. Parks,** of Centerville, for taking time from his medical practice to make his professional skills available to the college. Each year the yearbook is dedicated to an individual who has performed outstanding service to the college.

Dr. Einer M. Juel, of Atlantic, was re-elected president of the board of directors of the Southwest Iowa Mental Health Center, Inc., at its annual meeting held February 19 at the new center building. **Dr. John R. Hornberger,** of Manning, was elected a member of the board for a three-year term.

Dr. J. R. Long, Waterloo urologist, demonstrated the blood purifying machine at the St. Francis Hospital Alumni Association meeting in Waterloo on March 2.

Dr. John E. Rawls, of Ottumwa, has been named chairman of the educational and fund-raising cancer crusade to be conducted in Wapello County in April. Dr. Rawls served in this same capacity for the 1969 crusade.

Dr. Richard Bealka, director of the Independence Mental Health Institute Children's Unit,

was elected president of the Independence Rotary Club for 1970-1971 at the organization's February meeting. The program for the meeting was presented by **Dr. Selig Korson,** superintendent of the Mental Health Institute, who with his wife and two daughters recently toured Israel for 15 days. Dr. Korson briefed the Independence Rotarians on the background and geography of Israel and showed slides of the trip.

Dr. Norman Rinderknecht, of Des Moines, spoke at an educational seminar sponsored by the Christian Family Movement of the Drake Newman Community. The seminar was held at Drake University on March 1.

"Drugs and You and Yours," was the title of a program presented by **Dr. Gail M. Proffitt,** director of the Iowa State University Hospital, at a March 3 dinner meeting of the National Secretaries Association held in Ames.

Dr. William J. Neuzil, of Cedar Rapids, has retired after almost 60 years of medical practice. Although not in active practice for about two years, Dr. Neuzil had kept his office open on Wednesday afternoons to confer with old friends. Dr. Neuzil received his M.D. degree from the U. of I. College of Medicine and served his residency at North Chicago Hospital. He began his practice of medicine in Cedar Rapids in 1910.

Dr. Richard M. Caplan, professor of dermatology at the U. of I. College of Medicine, spoke on "Cutaneous Signs of Hematologic Malignancies" at the University of Nebraska College of Medicine on March 6. On March 18, he was a visiting professor at the Northern Louisiana College of Medicine in Shreveport, and gave two lectures, "Mast Cell Disease" and "Opportunistic Fungal Infection."

Three faculty members at the U. of I. College of Medicine have been granted Fellowships in the American College of Cardiology. They are **Dr. Donald L. Warkentin,** an associate professor of internal medicine, **Dr. Harry B. Weinberg,** clinical professor of internal medicine, and **Dr. Ronald M. Lauer,** professor of pediatrics.

Dr. James A. Clifton, professor and vice-chairman of the department of internal medicine, at the U. of I. College of Medicine, has been appointed by **Robert H. Finch,** secretary of the Department of Health, Education and Welfare, to the National Advisory Council on Arthritis and Metabolic Diseases of the National Institutes of Health. Dr. Clifton is president-elect of the Amer-

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Deaths

Dr. Phillip H. Tenney, 47, died at his home in Independence on Tuesday, February 3. At the time of his death, Dr. Tenney was assistant director of the out-patient department of the State Mental Health Institute. He came to Independence in 1963 to begin a residency program at the MHI. Previously, he had practiced medicine in Circle, Wyoming. He received his medical degree from the University of Illinois College of Medicine in Chicago and received training in neurology, pathology and psychiatry in New Orleans, Ft. Worth and Memphis. During World War II, Dr. Tenney served in the Medical Corps of the U. S. Army.

Dr. Vernon W. Petersen, 60, who began private practice in Clinton in 1946, died Wednesday, February 11, at his home. Dr. Petersen was a member of the Jane Lamb Hospital medical staff, co-chairman of the Jane Lamb Hospital expansion program, member of the board of trustees at Jane Lamb, past vice-president of the Iowa Medical Society, past president of the Iowa Academy of Surgery, and active in the Cancer Society on the state and county levels. He was a colonel in the United States Medical Corps during World War II, and served in the China-Burma-India Theater.

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Index to Advertisers

American Medical Association 265
Arch Laboratories 286
Arnar-Stone Laboratories 276

The Bankers Life 293
Bristol Laboratories 268
Burroughs-Wellcome & Co. 234B

Campbell Soup Company 260A
Casualty Indemnity Exchange 295

Dow Chemical Company 286A

Geigy Pharmaceuticals 234A, D, 235
Glenbrook Laboratories 231

Hoechst Pharmaceuticals 272
Hynson, Westcott & Dunning, Inc. 227

Lederle Laboratories 229
Lilly, Eli, & Company 225, 246

Medical Protective Company 289
Merrell, William S., Company 275

National Drug Company 226, 278A, B

Polk County Medical Society 243
Poythress, Wm. P., & Company 234C
Prouty Company 287

Robins, A. H., & Company ... 242A, B, 260D, 270, 286B
Roche Laboratories 296

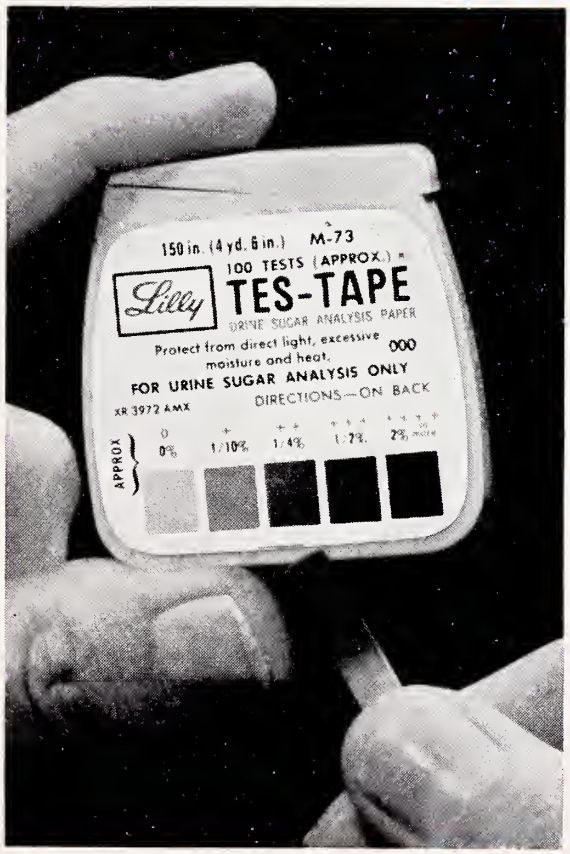
Searle, G. D., & Company 260B, C
Seven-Up Bottlers of Iowa 288
Silver Shield Plan 288
Smith, Kline & French Laboratories 245

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IN THIS ISSUE

- Hospital Administration and Medical Staff: Working Together for Innovation—Gerald W. Mungerson
- Malrotation of the Midgut—Joseph A. Cox, M.D., and Robert T. Soper, M.D.
- Uterus Didelphys With Adenocarcinoma in One Fundus—A Case Report—Kingsley B. Grant, M.D., and Richard L. Sedlacek, M.D.
- Treatment of Traumatic Paraplegic Patients by Localized Cooling of the Spinal Cord—Gaston J. Acosta-Rua, M.D.
- Seven-Year Review of Maternal and Perinatal Deaths—Madelene Donnelly Healy, M.D.



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Vol. LX MAY, 1970 No. 5

CONTENTS

Hospital Administration and Medical Staff: Working Together for Innovation
Gerald W. Mungerson 311

SCIENTIFIC ARTICLES

Malrotation of the Midgut
Joseph A. Cox, M.D., and Robert T. Soper, M.D. 317

Uterus Didelphys With Adenocarcinoma in One Fundus—A Case Report
Kingsley B. Grant, M.D., and Richard L. Sedlacek, M.D. 324

Treatment of Traumatic Paraplegic Patients by Localized Cooling of the Spinal Cord
Gaston J. Acosta-Rua, M.D. 326

Seven-Year Review of Maternal and Perinatal Deaths
Madelene Donnelly Healy, M.D. 329

EDITORIALS

Spaceship Earth 333

Importance of Advising the Patient 334

Tetanus and Polio Immunizations 336

Urge ECG to Detect Asymptomatic Infarcts . . 337

SPECIAL DEPARTMENTS

The Month in Washington 305

Coming Meetings 308

President's Page 332

In the Public Interest facing page 338

University Hospitals Drug Letter: "Degerming Solutions for Surgical Scrub and Skin Preparation"—John A. Guis, M.D. 339

Iowa Association of Medical Assistants 343

Information from the Iowa Heart Association: "Etiology and Pathogenesis of Hypertension"
Harriet P. Dustan, M.D. 344

The Doctor's Business 349

Journal Book Shelf 350

State Department of Health 353

Woman's Auxiliary News 356

Personals 359

Deaths 365

MISCELLANEOUS

Appoint Dr. Eckstein U. of I. Medical Dean . . 309

U. of I. Cardiology Division Offers New Program 328

IRMP Initiates Medical Literature Network . . 331

New Surgical Division Established 351

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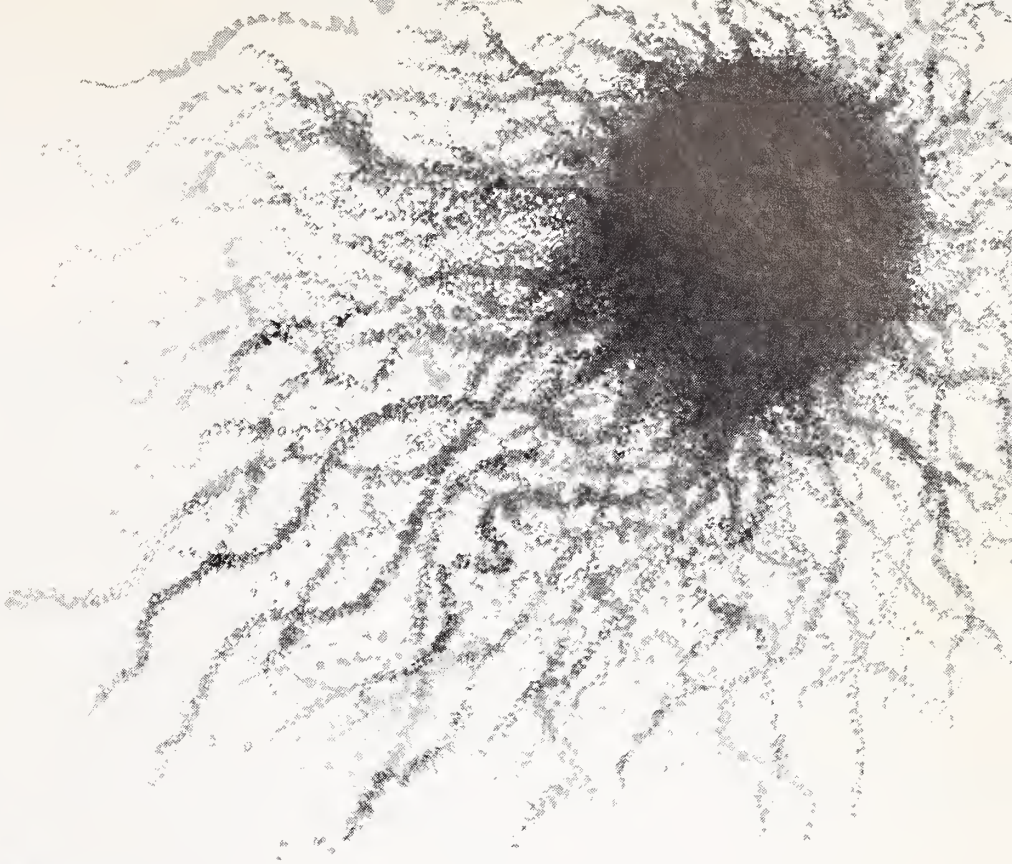
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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REVISED PRESCRIBING INFORMATION

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General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

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Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

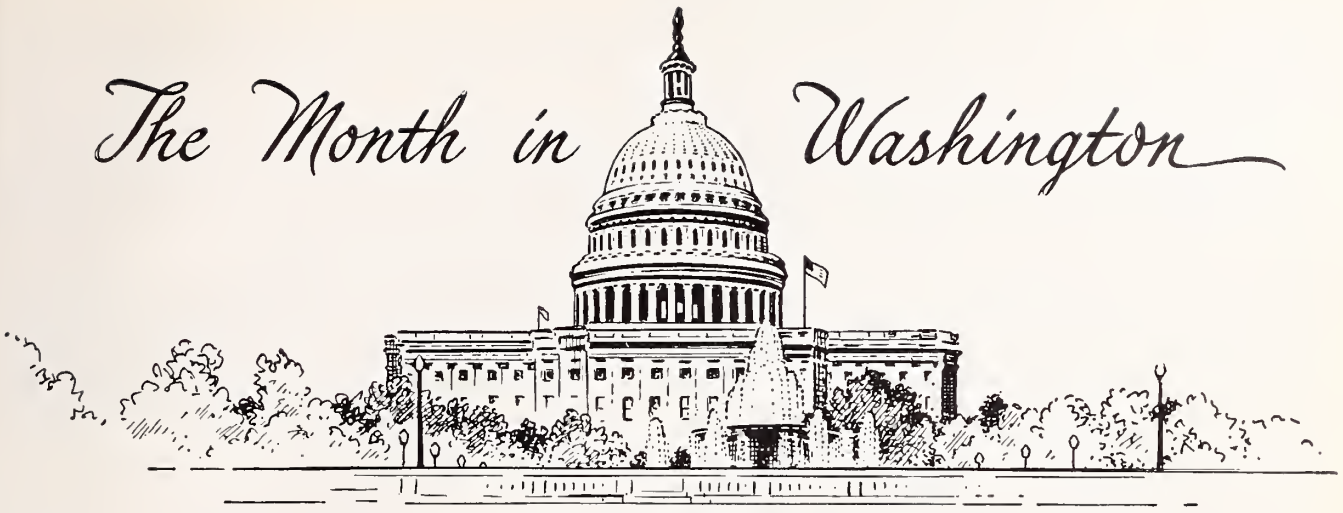
Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

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The Month in Washington



Washington—The Nixon Administration proposed in April that prepaid, closed-panel group practice health care be authorized under both Medicare and Medicaid.

The American Medical Association has recommended to the House Ways and Means Committee a new Medicaid plan utilizing existing private health insurance mechanisms to replace the present program of health care assistance for the medically indigent.

Robert H. Finch, Secretary of Health, Education and Welfare, said Congress will be asked to approve legislation authorizing "health maintenance contracts guaranteeing health services for the elderly and the poor at a single fixed annual rate for each person served."

"In the case of Medicare," Finch said, "the patient will be entitled under such a contract to all of the usual Medicare services plus preventive services. The contract price will be negotiated in advance at an amount less than the Social Security Administration presently pays for conventional Medicare benefits in the locality.

"Similarly under Medicaid we are seeking authority for the states to offer to the poor the option of securing services under such health maintenance contracts. We propose to work with the individual states toward the modification of their present programs in this regard and to encourage their use of the experimental authority previously mentioned for the testing of a variety of different contractual arrangements.

"The cornerstone of this new option in federal health purchasing will be the opportunity for consumers to choose between alternatives. The ultimate goal will be to give every beneficiary of these programs a choice between obtaining services from a health maintenance organization or arranging for them in the usual way from individual doctors and hospitals. He will have the choice of withdrawing from enrollment in a health maintenance organization if he finds the service unsatisfactory. The government will have the choice of entering into arrangements with individual health maintenance organizations, subject to special standards including assurance that every contractor will serve persons of high medical risk as well as the healthy."

Earlier, HEW Under Secretary John G. Veneman told the House committee that it was planned to call the new approach under Medicare Part C—to provide all services covered under Parts A and B "plus preventive services." He estimated a saving of about $15 per person, but some committee members were skeptical that more services could be provided at less cost.

Both Finch and Veneman made clear that one of the main objectives is a fundamental change in the nation's system of health care delivery. They said states would be asked to repeal existing laws restricting prepaid group practice. They said that future federal Medicaid funds might be made contingent on states eliminating "legal barriers to all forms of health delivery organizations."

"Let me conclude by saying that our broad objective is to frame an effective and reasonable approach to meet the health needs of the American people," Veneman said. "Obviously the federal government by itself cannot redirect the total health delivery system. We can, however, do our best to make sure that the vast expenditures of the federal government in the health care industry are used in a way that will contribute to the evolution of an improved, more effective, more economical system to deliver health care to our people. To the extent we are successful, we will be delivering the maximum benefit from the public funds entrusted to us. But what is equally important, we will be providing valuable support for improvement of the total health care system, public and private. In that way, we will be helping to improve the delivery of health services for all the American people."

Dr. Russell B. Roth, speaker of the AMA House of Delegates, told the House committee that Medicaid "has demonstrated some weaknesses which badly need correction."

A new program, he said, should: "provide the Congress with a basis for reasonable predictable costs; ease the burden on the states; assure total

implementation; and while maintaining a level of quality, insure that the costs of the program remain within the range of acceptability."

The program recommended by the AMA had these features:

1. Each eligible person (or family) would receive a certificate to be redeemed by a qualified health insurance company offering a health insurance policy or contract of certain basic health benefits such as hospitalization, medical care, preventive care, and diagnostic and outpatient care.

2. The premium cost for such policy or contract would be assumed by the federal government from its general revenue fund.

3. The states, freed from the expense of financing the basic costs of health care for their indigent and medically indigent residents, could provide supplementary benefits. These might include, for example, skilled nursing home care and dental services.

4. The determination that an insurance policy or contract, and the company offering same, are "qualified" would be made by a state agency which customarily has that authority. However, changes in the scope of benefits, and guidelines or standards to be used by the insurance departments in judging the company and the plan it offers, would be established by a national board appointed by the President.

5. All individual and families below a certain level of income would be eligible to participate. A simple determination of eligibility could be made by the appropriate federal agency on the basis of income, or an even more refined criterion could be used such as tax liability. The program could require marginal needy families to participate in the expense of the premium charge by paying a small part of it, varying such participation in direct proportion to this tax liability.

6. For the lower income family there would be no deductibles and no co-insurance features.

7. To insure a high level of quality and to prevent cost escalation, the program would provide for a system of "peer review," organized and conducted in a manner to assure its success.

As to those services and charges which are within the purview of the medical profession, appropriate medical societies would be given the task of establishing a peer review mechanism that would, among other things, review individual charges and services wherever performed; review hospital and skilled nursing home admissions as to their medical necessity, and stays in hospitals and skilled nursing homes as to their continued medical necessity; and review the need for the professional services provided in the institution.

In the case of fraud or other clear intentional and gross misconduct, the peer review committee would be expected to bring charges before the appropriate licensing body.

To assist peer review committees in getting established and into operation, the program should provide for federal participation in the cost incurred in developing the program and its operation. To assure participation by members of the profession, those who serve on peer review committees should be held harmless from any actions or claims based on their decisions as to the necessity or quality of the services provided, or the reasonableness of the charge.

In the event that a peer review committee is not established by the appropriate medical society within a reasonable time, or although established is not functioning, the Secretary of Health, Education and Welfare in consultation with the medical society, would be empowered to appoint a committee to so act.

* * *

The American Medical Association supports the Nixon Administration's air pollution control bill (S. 3466) which gives the Department of Health, Education and Welfare power to set air quality standards for the nation.

The legislation also provides for intensified research in air pollution and for tough enforcement procedures on the national air purity standards.

The AMA also supports accompanying legislation providing for expanded research on ways to cut auto exhaust pollution and for pollution control standards for watercraft and airplanes.

* * *

States must report to the Internal Revenue Service each year on total payments to providers of Medicaid services under new regulations issued by the Department of Health, Education and Welfare.

Each year, states will file Internal Revenue Service Forms 1096 and 1099 giving amounts paid to physicians, dentists, pharmacists, opticians, nursing homes, hospitals and other individuals and institutions that provide service to Medicaid patients.

States will be required to identify each individual provider of service by social security number, and partnerships and corporations by an employer identification number.

States also must establish procedures for verifying with recipients whether services billed by providers were actually received. Such verification may be made by spot checking.

* * *

President Nixon approved a $65 million increase in the Veterans Administration medical care budget mainly to improve services for wounded Vietnam war veterans.

An increase of $50 million was authorized in the VA's medical budget for fiscal 1971 and $15 million for the remainder of this fiscal year. Nixon acted after reviewing a study by Veterans Administrator Donald E. Johnson of the scope of the veterans medical care program and the increasing difficulties it has faced in providing hospital and clinical care.

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1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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COMING MEETINGS

IN STATE

May 8 — **Conference on Battered Child Syndrome, University of Iowa College of Medicine,** Iowa City.

June 8-12 — **Internal Medicine, 1970—Old Principles—New Practice sponsored by American College of Physicians,** University of Iowa College of Medicine, Iowa City.

CONTINENTAL U. S.

May 3-6 — **Kansas Medical Society,** Wichita.

May 3-9 — **Hawaii Medical Association,** Hilton Hawaiian Village, Honolulu.

May 4-5 — **Congress on Environmental Health,** Statler Hilton Hotel, Washington, D. C.

May 4-29 — **Postgraduate Course on Medical Radioisotopes sponsored by Special Training Division of Oak Ridge Associated Universities,** Oak Ridge, Tennessee.

May 4-29 — **Postgraduate Course on Nuclear Medical Technology sponsored by Special Training Division of Oak Ridge Associated Universities,** Oak Ridge, Tennessee.

May 6-7 — **Postgraduate Course on Progress in Cardiovascular Disease,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.

May 6-8 — **American Association of Genitourinary Surgeons,** Cascades Hotel, Williamsburg, Virginia.

May 7-8 — **Third National Conference on Voluntary Health Agencies,** Statler Hilton Hotel, Washington, D. C.

May 7-8 — **Symposium on Progress in Diabetes and Insulin Research,** University of Nebraska Medical Center Campus, Omaha.

May 7-8 — **Postgraduate Course on Inhalation Therapy sponsored by University of Kansas Medical Center,** Battenfeld Auditorium, Kansas City, Kansas.

May 7-9 — **American College of Sports Medicine,** Western Skies Hotel, Albuquerque.

May 7-10 — **Florida Medical Association,** Diplomat Hotel, Hollywood-by-the-Sea, Florida.

May 9 — **American College of Psychiatrists,** San Francisco.

May 10-13 — **American Association of Plastic Surgeons,** Broadmoor Hotel, Colorado Springs.

May 10-14 — **American Urological Association,** Bellevue-Stratford Hotel, Philadelphia.

May 11-12 — **Postgraduate Course on New Concepts in Cardiac Arrhythmias,** Kansas University Medical Center, Kansas City, Kansas.

May 11-14 — **State Medical Society of Wisconsin,** Sheraton-Schroeder Hotel, Milwaukee.

May 11-15 — **American Psychiatric Association,** San Francisco.

May 13-16 — **Postgraduate Course on Trauma sponsored by Chicago Committee on Trauma of American College of Surgeons,** John B. Murphy Auditorium, Chicago.

May 14-16 — **Symposium on Cardiovascular Diseases,** Saint Francis Hospital, Hartford, Connecticut.

May 14-16 — **National Conference on Breast Cancer,** Brown Palace Hotel, Denver.

May 14-16 — **First Biennial Meeting of Western Conference on Criminal and Civil Problems,** Broadview Hotel, Wichita, Kansas.

May 15-16 — **Surgery and 15th Annual Trauma Day sponsored by University of Nebraska Medical Center,** Campus of Medical Center, Omaha.

May 15-17 — **Eleventh International Symposium on Vectorcardiography sponsored by Long Island Jewish Medical Center,** Hotel Americana, New Hyde Park, New York.

May 15-17 — **Teaching Workshop on Clinical Hypnosis and Psychotherapy,** Knickerbocker Hotel, Chicago.

May 17-20 — **Illinois State Medical Society,** Sherman House, Chicago.

May 18-20 — **Minnesota State Medical Association,** Duluth.

May 20-23 — **American Gastroenterological Association,** Sheraton-Boston, Boston.

May 20-22 — **Postgraduate Course on Clinical Aspects of Infectious Diseases sponsored by American College of Physicians,** University of Washington School of Medicine, Seattle.

May 21-22 — **Postgraduate Course on Advances in Dermatology,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.

May 21-22 — **Postgraduate Course on Cardiovascular Disease sponsored by University of Nebraska Medical Center,** Omaha.

May 21-23 — **Postgraduate Course on Pediatric and Adolescent Psychiatry sponsored by University of Florida College of Medicine, Pinellas County Medical Society and Florida Academy of General Practice,** Tides Hotel and Bath Club, Redington Beach, Florida.

May 22-29 — **10th International Cancer Congress,** Houston Civic Center, Houston.

May 24-27 — **American Thoracic Society,** Sheraton Hotel, Cleveland.

May 25 — **American Society of Clinical Oncology,** Houston.

May 25-27 — **American Gynecological Society,** The Homestead, Hot Springs.

May 27-29 — **Postgraduate Course on Heart Disease—Clinical and Pathological Correlation sponsored by American College of Physicians,** Georgetown University Hospital, Washington, D. C.

May 28-30 — **American Ophthalmological Society,** The Homestead, Hot Springs.

June 3-5 — **Postgraduate Course on Pathology, Pathologic Physiology and Clinical Aspects of Renal Disease sponsored by American College of Physicians,** Georgetown University Hospital, Washington, D. C.

June 8-9 — **Conference on Medical Staff Organization and Management sponsored by Catholic Hospital Association,** Convention-Exposition Center, Cincinnati.

June 8-12 — **Psychiatry and the Internist sponsored by American College of Physicians, University of Maryland Hospital and Psychiatric Institute,** Baltimore.

June 13-14 — **American Diabetes Association,** Stouffer's Riverfront Inn, St. Louis.

June 15-17 — **American Neurological Association,** Claridge Hotel, Atlantic City.

June 15-17 **Postgraduate Course on Cardiac Auscultation sponsored by American College of Physicians,** New York University School of Medicine, New York.

June 15-17 **Postgraduate Course on Blood Transfusion Therapy and Related Immunology sponsored by American College of Physicians,** Michigan State University, East Lansing, Michigan.

June 15-19 **Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta, Georgia.

June 15-20 **General Practice Review,** YMCA Conference Center, Estes Park.

June 18-19 **American Rheumatism Association,** Statler-Hilton Hotel, Detroit.

June 20-21 **Society for Vascular Surgery,** Conrad Hilton Hotel, Chicago.

June 21-25 **Annual Convention of American Medical Association,** Chicago.

June 22 **Fireside Grand Rounds presented by American College of Chest Physicians and American Medical Association,** Conrad Hilton Hotel, Chicago.

June 23-24 **American Medical Society on Alcoholism,** American Hospital Association Building, Chicago.

ABROAD

May 6-8 **Workshop-Type Symposium on Medical Intensive Care sponsored by American College of Physicians,** University of British Columbia, Vancouver, B. C., Canada.

May 8-13 **World Congress on Prevention of Occupational Accidents and Diseases (6th),** Vienna.

May 10-14 **Annual Meeting, German Oto-Rhino-Laryngology Society,** Hamburg.

May 11-13 **European Society for Experimental Surgery, 5th Congress,** Venice, Italy.

May 30-June 1 **Pan American Cancer Cytology Congress (4th),** Ocho Rios, Jamaica.

June 22-25 **6th International Congress, American Thyroid Association,** Vienna.

July 12-18 **International Society of Urology,** 15th Congress, Tokyo.

July 12-18 **4th Quadrennial World Congress of Gastroenterology,** Copenhagen.

Appoint Dr. Eckstein U. of I. Medical Dean

Appointment of John W. Eckstein, M.D., as dean of the University of Iowa College of Medicine was announced in April, following approval by the State Board of Regents.

Dr. Eckstein will assume his new position June 1. He has been serving as associate dean for Veterans Administration Hospital affairs and professor of internal medicine.

William O. Rieke, M.D., professor and head of anatomy, has served as dean pro tem since September, 1969. He will continue as chief administrative officer of the College until Dr. Eckstein assumes the post.

Dr. Eckstein, 46, was born in Central City and received the bachelor of science degree from Loras College in Dubuque in 1946. He served in the Army Air Corps during World War II. He earned the doctor of medicine degree from the University of Iowa in 1950 and interned at Letterman General Hospital in San Francisco. He then returned to Iowa City to begin specialty training in internal medicine.

A specialist in cardiovascular diseases, Dr. Eckstein was appointed an assistant professor in 1956 and became a full professor in 1965. He served earlier as an instructor and research fellow for both the Rockefeller Foundation and the American Heart Association.

From 1958 to 1963, Dr. Eckstein was an Established Investigator of the American Heart Association at the U. of I. Cardiovascular Laboratories. Long active in the programs of the Iowa and American Heart Associations, Dr. Eckstein is now a vice president, a member of the executive committee and board of directors of the AHA. He was president of the IHA in 1965.



Dr. Eckstein is a Fellow of the American College of Physicians and the American College of Chest Physicians and a member of numerous other professional groups. He is the author or coauthor of more than 183 scientific articles and abstracts.

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Hospital Administration and Medical Staff: Working Together for Innovation

GERALD W. MUNGERSON
Boston, Massachusetts

When approaching a subject as crucial as that of the medical staff and hospital administration working together it always seems wise to begin by identifying the problem. Let me quote a letter[1] to the editor of JAMA as a means of bringing the problem into focus.

"The threat to our medical freedom is a lot more subtle than that which we face from our government. It comes from our brethren in the field of hospital administration. These gentlemen have gone far in their quest for power as evidenced by the attitude of a recent applicant for the post of hospital administrator. In referring to his previous hospital, he described the hospital as *his* hospital and the doctors as *his* doctors and the board of directors as *his* board of directors. To him, all of these people played a subservient function to his ultimate aims. These aims are to form medical centers in which the hospital administrator would direct all activities.

"The hospital administrator at one time was a man of consequence and upon his shoulders fell the burden of the financial solvency of the hospital. Today he has little to worry about, all he has to do is operate within the Blue Cross formula which is not always the most economical.

"The responsibility for the high cost of hospitalization is directly attributable to these gentlemen; they have a tendency to create small empires and to be wasteful in manpower and materials. The abuses in the field of hospital administration are brought about by the fact that hospital administrators operate in an area which could be well described as a 'no man's land' consisting of a board of directors, with the medical staff somewhere in the background.

"Under the pretext of conflict of interest the administrator is able to keep these two boards far apart. Under the guise of conflict of interest there is very little communication between these two boards except through the administrator, who is able to present his own views to the ruling body.

"The cost of hospitalization has skyrocketed while the doctor's fee has remained relatively stationary. The unknowing public makes little or no distinction between the cost of hospitalization and the fees of practicing physicians. The resulting consequence is that the medical profession as a whole bears the brunt of the criticism while the hospital administrator goes blithely about his business.

"I contend that to remedy this situation more doctors should participate in the decisions of the board of trustees as trustees. Instead, an ever-increasing chasm between administrators and doctors is becoming more apparent as time passes. The current trend seems to be to relegate the doctor to anonymity, the status of the doctor dwindles and the status of the administrator takes on greater dimensions. Perhaps it is time for a self-evaluation by the administrator. It would seem that the administrator has lost sight of the fact that it is the doctor and patient around whom the hospital revolves.

"There is no question that the 'concept' of total medical care for the patients would be enhanced if there were more communication between the board of directors and the doctors. There is also no question that the operation of the hospital would be much more economical and efficient."

The title of this letter "A Threat to Medicine" is appropriate for it identifies what could very possibly happen if hospital administration and medical leadership pull in opposite directions. The letter is quoted in its entirety not to suggest that the problem is all one sided; I certainly do not imply that all physicians hold this viewpoint. It does, however, represent a

Mr. Mungerson is general director, Boston Hospital for Women, Boston, Massachusetts. This article is adapted from a presentation made by Mr. Mungerson at the 1969 Annual Meeting of the Iowa Medical Society.

viewpoint which is not altogether uncommon. Indeed, sadly, some of what the author says is undeniably true.

In evaluating administrator-medical staff relationships I cannot resist the opportunity to reacquaint you briefly with the hospital administrator of today. He is professionally educated and earns a graduate degree. His is an emerging profession still striving for identification. Recounting the past perhaps may give some insight into the future role of the professional hospital administrator. The profession itself has passed through three distinct phases in its evolution. There was first of all the retired doctor or retired nurse era in which the hospital was obviously held together and seldom led. Neither was at the peak of his or her career; neither was in his or her original profession, and neither had a great deal of status. The second era of hospital management is represented by the quasi-business manager or hotel manager; this was the middle ages of hospital administration in that we mastered the hotel function of the hospital. Progress was made in solving the housekeeping, dietary and other physical and fiscal problems. In this era the hospital director may or may not have been a course graduate. More than likely he was an able person from a lesser role in the hospital hierarchy. The current hospital administrator is a professional whose motivations, and I become more convinced of this as I interview prospective students, are as intense as any medical students. These are young men who want to have an impact on health care and have chosen hospital management as their way of making a contribution.

INCREASED EDUCATION REQUIRED

Formal education is represented by a two-year program leading to the Master's degree. This is followed by a preceptorship—a first job of up to three years duration during which the administrator has his clinical practice.

Like the role of the administrator, however, the education has changed and evolved. During the retired doctor or retired nurse superintendent era there was no professional education. The quasi-business manager had essentially a trade-school education and absorbed all he could about the departmental management of housekeeping, etc. The final era, at least the final in terms of our current perspective, is true graduate education even leading to a doctoral education, pioneered incidentally by the University of Iowa.

Let me briefly explain how I perceive the role of the hospital administrator. First and foremost he is a generalist surrounded by experts in his organization. For example, his staff typically would include a director of nursing, a controller, a systems and data processing manager, a public relations director, a personnel director, all of whom are professionals in their own right, and probably two younger generalists. You might rightfully say too many assistants; this will vary. His role as a generalist is obviously to bring to the production side or the specialists the philosophy of patient care as determined by the board of trustees, the medical staff and, of course, the community. In short his role is to produce.

SERVES THE COMMUNITY

The role of the hospital administrator is that of a community agent. If he is any good at all he will see his job as a responsibility to deliver patient care. The community expects it from him and of the hospital, and frequently he represents patient care to the community. He cannot escape or retreat from this viewpoint. If you have ever heard an administrator at a Rotary or Kiwanis meeting or any community function you know he cannot withdraw from questions about patient care in the community.

The administrator is a man in the middle. Below him are the employees. Above him is the board and on either side are the medical staff and auxiliary. He is surrounded by people responsible for and interested in patient care. He can obviously be in the eye of a hurricane somewhat oblivious to what is going on around him. Or he can do what he should by keeping himself in the middle of the crossfire, and in the process maintaining the flow of communications.

Finally, the growth of the hospital itself has thrust upon him the perspective of the president of a large corporation. In the last 15 years we have at least doubled our size by every conceivable measure including per patient day cost. We have added complicated services such as intensive care, coronary care, kidney dialysis, etc. We are, in fact, becoming a health center, whether we are consciously planning it or not. In short the hospital administrator is

groping to become a true professional who will be professionally motivated and satisfied the same way as a physician—knowing he is making a contribution and wanting to be an influence on health care.

We need not be on a collision course, however, for the simple and obvious fact is that our goals are identical. We should work together. That phrase, however trite it may be, brings to mind a TIME MAGAZINE quote by Daniel Patrick Monihan in which he said something to the effect that the United States is for peace in the world, but that does not tell the Secretary of State what to do every morning when he gets up. We are for working together but that does not tell us how; my assignment is to suggest a way in which we can.

There are many ways of integrating the physician into the hospital management structure. First of all, there is the salaried physician who is paid for his job. I submit that the hospital has no more or less control over a physician by virtue of his method of pay than it does by any other means. In short, this is no guarantee of integration into the management. There is a form of hospital organization which has the equivalent of a vice-president for medical affairs, who represents the physician in top management. The problem here is that it tends to isolate responsibility in one person and really segregates more than it integrates. There is the triad method of management, a very promising method currently being expanded at the Evanston Hospital in Evanston, Illinois. It integrates at the lowest possible organizational level, that is the level closest to patient care—the nurse, the physician and the administrator—so that patient care decisions can be made at the bedside, rather than going up separate organizational routes. There is growing a method of paying the physician for his part-time contribution to hospital management. For example a physician may receive a salary of $5,000-$6,000 per year for his part-time management of the Outpatient Department. Part-time commitments generally get part-time results.

COMMITTEE RESPONSIBILITY

There is the very traditional and still common method of the hospital expecting its staff members to contribute a portion of their time to medical education and/or hospital committee responsibility. This is culminated in the well-known joint conference committee, which is designed to integrate physician, trustee and administration. Gaining momentum is the idea of having a physician on the board of trustees. The influence of boards of trustees on the daily activities of the hospital is necessarily very limited and, in addition to isolating this physician board member from his colleagues, his opportunity for contribution is not as great as we would like to think. Finally, of course, there is the extreme position—that of actual hospital ownership by the physician. All one has to do is to look around the country to make the obvious discovery that the hospital owned and operated for a profit does not make a large commitment to research or education and, in fact, it is not the community hospital we are thinking of.

MUTUAL RESPECT

The above mentioned systems are in practice with varying degrees of success. Each can work. But they will work only if two conditions are prevalent. First is a healthy mutual respect between physicians and administrators. Hospital management as a profession must gain respect as every profession gains respect—by earning it. The respect of hospital administrators for the medical profession and the need for individual and collective responsibility among physicians for patient care decisions is not challenged and hopefully never will be. To build mutual respect, the administrator of the hospital must sit down with the senior physicians of the organization on a frequent, regular and formal basis. For example, the chief of staff and his two top associates and I confer each Monday for at least two hours. We go over matters important to the hospital and attempt to make decisions jointly.

The second necessary ingredient for working together is an open mind; each profession simply must change some of its traditional thinking. The hospital administrator must recognize something that Robert Cunningham, well-known editor of MODERN HOSPITAL magazine, says:

"The reason I am talking here about doctors instead of hospitals will be obvious to everybody except doctors and hospital administrators. These are the only people in the world who think there can be some separate consideration of the latter without the former

and who think that the management of medical institutions can be considered separately from the medical care rendered in these institutions. The thing that is newsworthy and exciting about the hospital is doctors and patients, not management."[2]

Despite our position, i.e., a generalist position, responsible for patient care, we cannot allow ourselves to think the management and organization of hospitals is the end-all and decisions have to be made in that framework. It follows, then, that the hospital administrator must give up some decision-making to the physician. He must realize he is surrounded by very well educated, motivated, knowledgeable people who know more than he can ever hope to know about the operating rooms, the laboratories, and most importantly, planning.

THE BROAD PICTURE

What about the physicians? Let me paraphrase comments from a past AMA president, Dr. Milfred Rouse.[3]

Dr. Rouse made several points particularly pertinent to administrators and physicians about their relationships. He first of all implored physicians to avoid gunbarrel vision and recognize the broad picture of the total hospital operation, recognize that it is becoming a health care center.

Dr. Rouse asked the physician to increase his sense of responsibility to the hospital. He said physicians too often identify more with agencies outside their own hospital. The physician must accept a sense of responsibility to his hospital.

Dr. Rouse suggests that the physician must modify his tendency to close ranks against anyone without an identical background. This relates to the previously mentioned matter of mutual respect. I would add to Dr. Rouse's suggestions one which has been offered many times before: the physician must recognize that medicine today is a team effort, albeit the physician's will to forever remain the key and leader; he must rely upon well prepared team members who are just as equally concerned and committed to patient care, and of course he must treat them accordingly.

My appeal really has no gimmick—there is no direct route to follow—it is simply a recognition of one another's responsibilities. How does all this relate to providing health care in rural areas? How can a Boston hospital administrator comment on health care in Iowa? There are comparisons between the problems of the rural area and those of the ghetto. We are faced with the problem of access to medical care. When a patient can live two blocks from one of the world's largest medical centers and present herself at the admitting office in acute labor never having seen a physician we have problems of access to medical care. Transportation is perhaps more of a problem in the cities than it is in the rural areas. When a patient can die in an ambulance within sight of the emergency room because traffic is so clogged no one can move, that is as acute a problem as being 40 miles away from the hospital emergency room or doctor's office.

The manpower shortage is well known to you but in the cities it is extremely acute. The ghettos do not have large numbers of citizens capable and trained to provide care to their neighbors, nor is it easy to get professionals from the hospitals to work in the ghetto area when opportunities abound elsewhere. There are similarities between urban and rural problems.

The hospital is increasingly becoming a health care center. I hope you will agree that this is logical and that it should continue. That is where the people are, that is where the transportation and communication needs can best be met, where the training of medical personnel will take place. In short, it is around the hospital where the resources are; therefore, this is where the delivery of care will be centered, both in the ghetto and in the rural areas.

The role of the hospital administrator in these very similar situations is akin to the role of the contractor. Let him build the system and help deliver the goods after you have written the specifications, and together we will monitor the end product. Together we have all the intellectual energies and strengths necessary to solve the problems. Separately there is little hope.

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Scientific Articles

Malrotation of the Midgut

JOSEPH A. COX, M.D. and
ROBERT T. SOPER, M.D.
Iowa City

Midgut malrotation is one of the most variable and potentially dangerous of all the congenital intestinal anomalies. It may be asymptomatic and compatible with a normal life expectancy, and thus interesting only as a curious misadventure in intestinal development. On the other hand, malrotation with volvulus can strangulate the entire midgut and kill the patient within a few hours, at any age. Perhaps its commonest manifestation is partial or complete duodenal obstruction, occurring acutely, intermittently or chronically during infancy and childhood. Chronic, non-strangulating volvulus is heralded by such varied manifestations as diarrhea, protein-losing enteropathy, chylous ascites or simple "failure to thrive."

With this bewildering spectrum of presenting complaints, it is small wonder that the possibility of midgut malrotation often is late in coming to mind. The overall incidence of the anomaly is difficult to establish. Several reported series[2,3,6,7] rank malrotation of the midgut with intestinal stenosis or atresia and Hirschsprung's disease as one of the commonest causes of neonatal intestinal obstruction.

During the past eight years, we have recognized 29 cases of malrotation of the midgut at the University of Iowa Hospitals. In order to obtain a relatively "pure" spectrum of cases, we have excluded patients with associated hernia of the foramen of Bochdalek, gastroschisis and omphalocele. We have also excluded patients with anomalies of fixation such as volvulus of the cecum, paraduodenal hernia and extrinsic adhesive obstruction of the duodenojejunal junction. In all patients in this series, the diagnosis was confirmed at operation.

EMBRYOLOGY

During the fourth to twelfth weeks of embryonic life, the gastrointestinal tract elongates enormously, herniating into an extracoelomic sac at the umbilicus. It rotates 270°, and then returns in an orderly manner to the abdominal cavity (Figure 1). Aberrations in this complex process produce the clinical problems which we shall discuss in this paper.

By the fourth gestational week, the fetal intestine has developed sufficiently to permit identification of its three subdivisions based on blood supply: foregut, midgut and hindgut. The foregut is supplied by the celiac axis; the midgut by the superior mesenteric artery; and the hindgut by the inferior mesenteric artery. That portion of the midgut proximal to the superior mesenteric artery is labelled the duodenal-jejunal loop, in contrast to the ceco-colic

Dr. Cox is a former surgical resident at University Hospitals, Iowa City, and is now a resident in pediatric surgery at the University of Cincinnati. Dr. Soper is a professor of Surgery at the U. of I. College of Medicine.

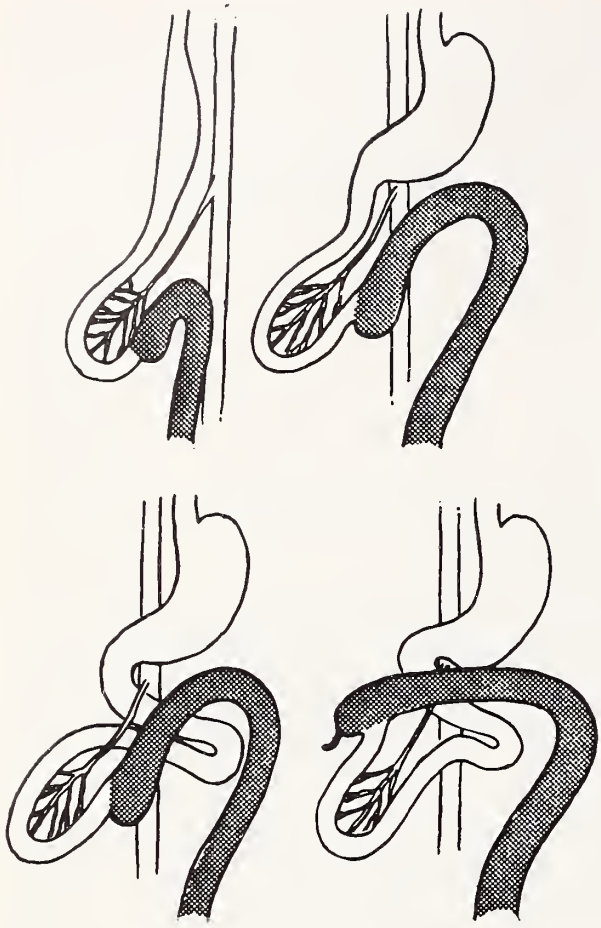


Figure 1. Diagram of normal embryonic midgut development; the colon is shaded, and the vessel seen is the superior mesenteric artery. The upper left picture is a lateral view showing the earliest midgut elongation. The other views are seen in the anteroposterior projection. The upper right picture shows the first 90° rotation, the lower pictures the coincident elongation and further 180° of counter clockwise rotation.

loop which is distal to the vessel. Snyder and Chaffin[11] have demonstrated that after midgut elongation and herniation have been nearly completed, the duodenojejunal loop begins to return to the coelomic cavity first (Figure 1—lower-left picture). This loop normally rotates through 270° (in a counter-clockwise direction as viewed by the examiner as he faces the patient), with the superior mesenteric artery as its axis, and the duodenum comes to rest behind (caudad to) the superior mesenteric artery. The ceco-colic loop also rotates through 270° in a counter-clockwise direction, but returns to the abdominal cavity slightly later than the proximal loop, with the transverse colon lying anterior (cephalad) to the superior mesenteric artery (Figure 1—lower-right picture). The cecum is the last segment of bowel to return to the coelomic cavity, and it occupies the right upper abdominal quadrant.

Fixation of the duodenum and descending colon to the posterior parietes occurs early, but descent of the cecum to the right lower quadrant and its fixation there occurs over a much longer period, spanning the rest of gestational life and often extending into postnatal life. During this development the root of the small-bowel mesentery becomes attached along a broad front extending from the ligament of Treitz to the right iliac fossa. The breadth of this mesenteric attachment normally prevents volvulus.

For as yet undetermined reasons, elongation, rotation, return and fixation may cease at any point on this continum. Therefore many anatomic abnormalities are possible, and they have been classified in many ways by various authorities. The classification which we have adopted was suggested by Bill and Grauman[1]: (a) nonrotation; (b) incomplete rotation; and (c) reverse rotation. These categories relate the positions of the duodenal-jejunal and the cecal-colic loops in relation to the superior mesenteric artery. In nonrotation the midgut is suspended only by a midline dorsal mesentery (Figure 1—upper-left picture). Because nonrotation occurs only with omphalocele, gastroschisis and foramen of Bochdalek hernias, they have been excluded from our series.

Reverse (clockwise) rotation occurs after the initial 90° counter-clockwise rotation of the midgut has located the duodenum in the right upper abdominal quadrant, the duodenal-jejunal loop ending up anterior (cephalad) to the superior mesenteric artery. It was found in one of our patients. Twenty-eight of our cases represented incomplete rotation, with arrest after approximately 90° of counter-clockwise rotation (Figure 1—upper-right picture).

AGE, SEX, HOSPITAL STAY

Our patients ranged in age, at the time of diagnosis, from one day to 14 years (Table 1). One half of our patients were admitted within 10 days following birth, and that figure is in general agreement with those in other reports.[5-11] There were 16 males and 13 females in our series. The average hospital stay was 20 days for surviving patients.

TABLE 1

MALROTATION

Age at Diagnosis	
1 day	4
<30 days	17
1-12 months	8
4-14 years	4
	29

CLINICAL FINDINGS

All 29 patients had vomiting as the chief complaint, and bile-staining was indicated in the 19 cases where the history mentioned the vomitus color (Table 2). Less common com-

TABLE 2

MALROTATION

Major Complaint	
Vomiting	29
Bilious	19
Cyclic	1
Feculant	1
Stool pattern	
Constipation	2
Diarrhea	3
Melena	1
Abdominal pain >4 years	3/4

plaints were constipation, diarrhea, bloody stools and fecal vomiting. Two infants with either bloody stools or fecal vomiting died, and these grave prognostic signs herald midgut volvulus with obstruction and strangulation.[3] Colicky abdominal pain was experienced by three out of the four patients old enough to voice this complaint.

Dehydration, abdominal distention and icterus were common physical findings (Table 3), in order of decreasing frequency. Signifi-

TABLE 3

MALROTATION

Px	
Icteric newborns	6/17
Dehydration	11/22
Abd. distention	8/22



Figure 2. Typical barium enema in newborn with midgut malrotation. The colon is small and occupies the left hemiabdomen, with the cecum lying in the right epigastrium. The gas-filled, obstructed duodenum and stomach lie above the proximal colon.

cant abdominal distention was found in only eight patients. Seven of the 17 newborns weighed less than 2,500 Gm. at birth, and six were jaundiced on admission. Jaundice has been reported previously in association with malrotation, and some interesting mechanisms have been proposed as explanations for it.[8] The icterus resolved promptly after operation in our patients, without any untoward complications.

X-RAY FINDINGS

Barium enema suggested malrotation in 20 out of the 24 patients on whom this study was performed (Figure 2). Three barium enemas were indeterminate, and one was thought to be normal. In 12 patients—all of those in whom it was performed—barium contrast studies of the upper gastrointestinal tract showed obstruction of the third portion of the duodenum. Plain abdominal radiographs were nearly as diagnostic as the contrast studies, revealing the "double bubble" of duodenal obstruction in 12 of 17 cases (Figure 3). Only one such x-ray was interpreted as normal.

ASSOCIATED ANOMALIES

Four of our patients who succumbed harbored other major congenital anomalies. Two patients had esophageal atresia with tracheo-



Figure 3. Supine radiograph of abdomen in newborn with midgut malrotation. The "double bubble" of complete duodenal obstruction is clearly shown.



Figure 5. Operative photograph of infant with non-strangulating midgut volvulus. The volvulized bowel has been exteriorized onto a laparotomy pad. Note the clockwise twist at the root of the mesentery and the plethoric, edematous and thickened bowel and mesentery. Dilated lacteals were clearly visible, and chylous ascites was present.

esophageal fistula. One of these two also had an intrinsic duodenal membrane, and the other had imperforate anus, annular pancreas and bladder-neck obstruction. The third patient had syndactyly and multiple areas of small-bowel atresia. The fourth had a cleft palate, stenotic right ureter, cystic pancreatic lesions and giant-cell hepatitis.

OPERATIVE FINDINGS

In 28 of our patients laparotomy revealed incomplete midgut rotation, with arrest after 90° of counter-clockwise rotation. The duodeno-jejunal loop occupied the right hemiabdomen, and the ceco-colic loop lay on the left side. The cecum was located in the upper abdomen in all patients. In all 22 cases explored first at this hospital, "Ladd's bands" were indentified, which extended from the right posterior parietes to the cecum, running across and extrinsically compressing the duodenum to some degree (Figure 4). Seven patients were first explored elsewhere.

Midgut volvulus of at least 180° was documented in 23 cases (Figure 5). Massive small-bowel necrosis was found in three patients. Chylous ascites occurred in three patients with chronic, non-strangulating volvulus which was cured by operation. This phenomenon is best explained by leakage of chyle from the dilated, partially obstructed lymphatic channels occasioned by the twisted mesentery. One newborn had multiple areas of small-bowel atresia, and another subsequently proved to have a membrane obstructing the duodenum.

TREATMENT

After the peritoneal cavity is opened, the entire gut is exteriorized from the abdominal cavity. Volvulized midgut is reduced in a counter-clockwise manner to improve arterial inflow, reduce venous and lymphatic congestion and relieve the closed-loop intestinal obstruction. Necrotic bowel should be resected. Bowel having questionable circulation is kept warm and moist, and is reevaluated at the end of the procedure. Ordinarily, resection is preferable to leaving bowel of borderline viability. However, if the entire midgut is questionably viable, one may choose to inspect it again in 24 hours, and then resect the frankly necrotic segments, in preference to the certain mortality of total midgut resection.

After general exploration, in which one looks especially for areas of atresia, he should direct his attention to the fixation bands which cross and obstruct the duodenum, spanning the space from the right upper posterior parietes to the cecum (Figure 4). After lysis of these bands, the duodenum and jejunum drop straight down the right gutter into the right lower quadrant, and the small bowel fills the right hemiabdomen. The ascending and transverse colon are next reflected to the left side of the abdomen. This is essentially what Ladd described in 1936.[6] We use no fixation sutures such as Bill and Grauman[1] suggested.

Appendectomy was performed on 23 of our patients to obviate the confusing potential of subsequent left-sided appendicitis. Gastrostomy was used 17 times, first to pass a Foley catheter bag through the duodenum to rule out intrinsic obstruction, and then to provide postoperative decompression. Two patients originally operated upon elsewhere required take-down of anastomoses which had been mistakenly constructed to bypass the obstructed duodenum—one a gastro-ileostomy and the other a gastro-jejunostomy.

Of the 22 patients who were operated upon originally at our institution, four required reoperation. Three patients had lysis of partially obstructing adhesions between loops of small bowel, and subsequently they have done well. The fourth required bypass of a partial intrinsic duodenal membrane which had been overlooked at the first laparotomy.

Seven patients had been explored first by other surgeons. Three patients had had pyloromyotomy for what was thought to be hypertrophic pyloric stenosis, but because of persistent symptoms they were later referred to the University of Iowa Hospitals. It is impossible to know whether pyloric stenosis was actually present in these cases. Another patient required lysis of obstructing postoperative adhesions four years after the initial exploration. This patient's incomplete rotation had been recognized during the previous laparotomy and had been treated appropriately.

The fifth patient had undergone resection of an unknown length of small bowel strangulated by volvulus, and later was referred to our hospital with intractable diarrhea. Our initial thought was that a "short gut syndrome" had caused the diarrhea—an impression disproved at laparotomy, when a measured 62 cm. of small bowel remained after the lysis of many obstructing adhesions as well as residual Ladd's bands.

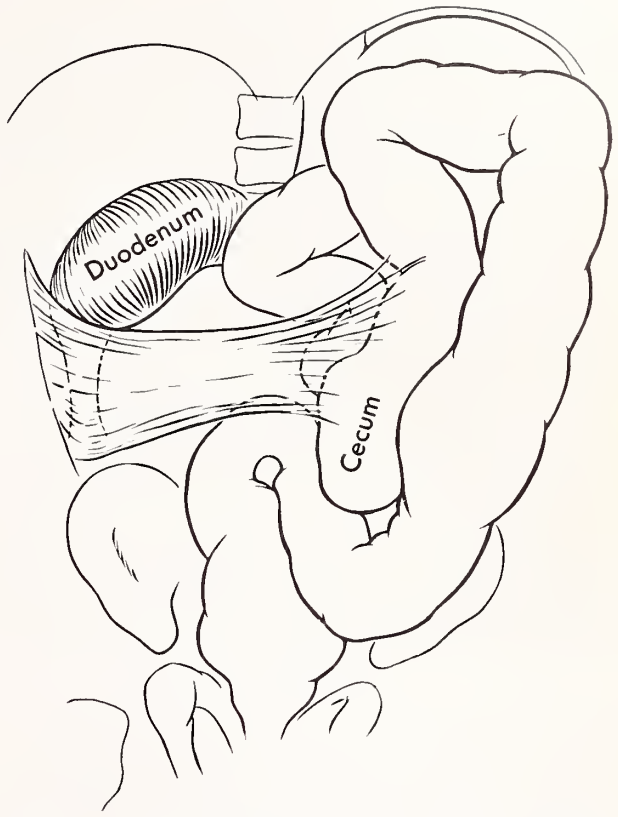


Figure 4. Diagram showing "Ladd's bands" extrinsically obstructing the duodenum; the entire colon is in the left hemiabdomen.

Another patient had had ligation of a tracheo-esophageal fistula, a surgical bypass of what had mistakenly been thought an annular pancreas, and a colostomy for imperforate anus at another institution. When we reexplored the child, we took down the gastro-ileostomy, and recognized and appropriately treated the malrotation.

The final patient who had been operated upon before referral to our hospital was an infant who had a gastrojejunostomy for duodenal obstruction. Persistent vomiting and wound disruption prompted referral here. where a malrotation with Ladd's bands was corrected.

POSTOPERATIVE COMPLICATIONS

Three patients had diarrhea for one to three weeks postoperatively, and two of them had had small-bowel resections. One of the latter

patients was cured by release of obstructing adhesions at a second operation. The other patient had evidence of a "short gut syndrome." She subsequently required a second admission for dehydration due to intractable diarrhea, and has recently been lost to follow-up. Two patients had wound infections, and one of those dehisced twice. Two patients had prolonged ileus requiring intravenous fluids and nasogastric suction for longer than one week postoperatively.

One patient had persistent signs and symptoms of duodenal obstruction, and was reexplored on the sixth postoperative day for bypass of an overlooked duodenal stenosis. Had we passed a Foley catheter with an inflated balloon through the duodenum at the time of operation, we would have discovered that additional obstruction.

MORTALITY

There were seven deaths in 29 cases—a hospital mortality of 24.1 per cent, which is in general agreement with the mortalities in previously reported series.[5-11] Two patients died of pneumonia associated with tracheo-esophageal fistula.

Three patients died with infarcted small bowel. One of these had resection of multiple atretic segments of small bowel, with an end-to-end anastomosis. An overlooked intrinsic web in the distal ileum produced continuing obstruction, leading to infarction and perforation. Another patient was admitted in extremis, and at laparotomy had patchy areas of questionable viability of the entire midgut. The volvulus was reduced, and Ladd's bands were lysed. We planned to reexplore the child in 24 hours in hopes that the area of necrosis would be better delineated, but the patient died within eight hours following surgery. The third patient had reduction of non-strangulating volvulus, the bowel being edematous but definitely viable. At autopsy, 24 hours later, the entire midgut was infarcted, but the cause was not clear. The middle colic artery was hypoplastic but patent, as were the other arteries and veins supplying the midgut. There was no evidence of persistent volvulus, stenosis or intramural membrane.

Another of our patients had had a gastrojejunostomy elsewhere for duodenal obstruction, and because of persistent vomiting and wound dehiscence, was referred to our institution. At reexploration, malrotation with Ladd's bands was corrected. Initially the patient did well, but on the third postoperative day the wound again dehisced. After secondary closure the patient developed peritonitis, became septic and died.

The final fatality in our series was hospitalized elsewhere for the first six weeks of life because of intermittent vomiting. She was referred here with severe malnutrition and dehydration. After surgical treatment for malrotation, she developed peritonitis, and septicemia, and expired. At autopsy the patient proved to have giant-cell hepatitis, cystic pancreatic lesions and stenosis of the right ureter.

FOLLOW-UP

Six of the patients who left the hospital alive have been lost to follow-up. One patient succumbed at home one year later from trauma. We have a current follow-up on 16 patients, for periods averaging three years. All are well and exhibit normal growth and development. Two patients have occasional episodes of diarrhea. Another patient has a convulsive disorder that is currently under investigation.

DISCUSSION

Some degree of partial duodenal obstruction, heralded by bilious vomiting, is the salient clinical feature of midgut malrotation. Abdominal distention occurs when non-strangulating volvulus produces closed-loop midgut obstruction, with pooling of succus entericus or ascitic fluid. Cataclysmic deterioration in the patient's condition, often with shock and bloody diarrhea or feculant vomiting, signals the conversion to strangulation of the volvulized midgut.

The diagnostic workup is tailored to the urgency of the clinical picture. Plain abdominal radiographs generally suggest duodenal obstruction, and are the only studies necessary if strangulating volvulus is likely. Barium enema should precede cinefluoroscopy of the upper GI tract, if the child's condition allows such a leisurely and complete workup. Final confirmation of the diagnosis must await laparotomy.

At laparotomy, the bowel must be completely eviscerated to permit proper identification of the abnormality and to allow precise

surgical correction. Five patients were referred to us after inappropriate operations—three following pyloromyotomy for questionable hypertrophic pyloric stenosis, and two following bypass procedures for duodenal obstruction. Adequate exposure might have prevented these diagnostic and treatment errors. We recommend a generous right supraumbilical transverse incision.

Over the years, many methods have been recommended for dealing with the midgut following lysis of the fixation bands and derotation of the volvulus. These have ranged from Estrada's complete repair of the malrotation, returning the cecum to the right lower quadrant and fixation of the small-bowel mesentery,[4] to Bill's suture fixation of the colon in the left hemiabdomen.[1] We have avoided suture fixation, allowing the small bowel to occupy the right hemiabdomen and the colon to occupy the left hemiabdomen. Since there has been no recurrent volvulus in our patients, this simpler procedure seems justified.

However three of the 22 patients whom we originally corrected developed postoperative adhesive bands that produced mechanical small-bowel obstruction. This was probably related to denuding the duodeno-jejunal mesentery while lysing the fixation bands and unkinking the duodenum, as well as manipulating the midgut extensively. We have not felt that any type of suture fixation would prevent this postoperative problem, and we have directed our efforts toward protecting and being as gentle as possible in handling the bowel.

In two newborns in this series, intrinsic intestinal obstruction was overlooked. The cause was membranes within the duodenum and ileum. The duodenal membrane required later surgical bypass, but the occult ileal obstruction went unrecognized and ultimately killed the patient. It is imperative that intrinsic patency of the gastrointestinal tract be assured in newborns with midgut malrotation. This is expediently done by passing a catheter through a gastrostomy downstream into the jejunum and observing that injected saline enters the colon.

SUMMARY

We have reviewed 29 cases of midgut malrotation treated at the University of Iowa Hospitals during the past eight years. The cardinal symptoms are bilious vomiting and dehydration in a newborn or young child, often with a non-distended abdomen. Feculant vomiting, bloody diarrhea and signs of shock indicate midgut strangulation due to volvulus. Plain radiographs of the abdomen taken in the upright position reveal variable degrees of duodenal obstruction, and barium enemas characteristically show the cecum in the upper half of the abdomen. At operation the midgut must be totally eviscerated to allow precise recognition of the abnormality and its proper surgical correction. We recommend simple derotation of volvulus, division of the extrinsic bands obstructing the duodenum and appendectomy, with no attempt at completion of the rotation or suture-fixation. Newborns must have intrinsic patency of the midgut proven. Necrotic bowel must be resected.

Our mortality rate was 25 per cent, the deaths being associated with other major congenital anomalies, strangulation of bowel from volvulus, or inappropriate previous operations. Adhesive small-bowel obstruction was the most common complication requiring repeat operation. We continue to subscribe to the simple principles of surgical correction for midgut malrotation that were advocated more than 30 years ago by Dr. Ladd.[6]

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Uterus Didelphys With Adenocarcinoma in One Fundus—A Case Report

KINGSLEY B. GRANT, M.D., and
RICHARD L. SEDLACEK, M.D.
Cedar Rapids

THE CO-EXISTENCE of utero-cervical anomalies and malignancy has been of continuing medical interest for over half a century. The first definitive review of the literature by von Franque[1] in 1930 has been followed by several compilations[2, 3, 4] of subsequently reported cases. One of the most comprehensive was prepared in 1961 by Nicholson.[4] He listed 87 anomalies associated with malignancies. Fifty of these cases were carcinoma of the endometrium and 37 were carcinoma of the cervix. Not included was the case presented in the discussion following his own paper, and the case reported by Duncan and John[3] in 1962. Both of these were carcinoma of the endometrium and brought the reported total in that category to 52, for the period ending 1968. We wish to report the fifty-third case in the literature of carcinoma involving the endometrium of a congenitally abnormal uterus.

CASE REPORT

In November 1968, a 56-year-old nulligravida Caucasian woman was admitted to St. Luke's Methodist Hospital, in Cedar Rapids, because of left lower quadrant abdominal discomfort, pelvic mass and post-menopausal vaginal bleeding of three days duration. Nine months prior to admission a single episode of nonhemorrhagic vaginal discharge had occurred.

The patient had first been seen eight years earlier because of lower abdominal pain. Pelvic examination and subsequent laparotomy at that time revealed duplication of the vagina, cervix and fundus. A cervical os was visible on each side of the septate vagina, with the right introitus being notably larger than the left. The fallopian tubes and ovaries were not duplicated. They were attached to the *left* uterus. Several golf-ball size leiomyomas involved the left uterine body and broad ligament. Extensive pelvic adhesions were present, along with an acute right salpingitis and secondary periappendicitis. Appendectomy and right salpingectomy were performed. Cultures were negative. The patient was advised to have coitus on the left side of the vagina to enhance the possibilities of becoming pregnant. At follow-up examinations, "Pap" smears were negative but the leiomyomas were found to be enlarging. In 1963, the patient began to experience menopausal signs and symptoms. Hysterectomy was offered but steadfastly refused until the onset of vaginal bleeding in 1968.

Except for a pelvic mass, which was now estimated to be 6″ x 8″, physical examination and laboratory examination were within normal limits. Pre-hysterectomy D&C's were abandoned because uterine sounds could not be passed beyond 1″ without undue pressure and possible perforation of the uteri. Abdominal hysterectomy with bilateral oophorectomy and left salpingectomy were performed. Numerous dense adhesions were present with involvement of the urinary bladder, small intestines and rectosigmoid.

No renal or other abnormalities were present.

Examination of the surgical specimen showed that except for serosal fusion at the level of the corpo-cervical junction, the ostia, endocervical canals, and endometrial cavities were entirely independent. Total weight of the specimen was 205 gm. Both uteri were extensively distorted by leiomyomas varying from 2 cm. to

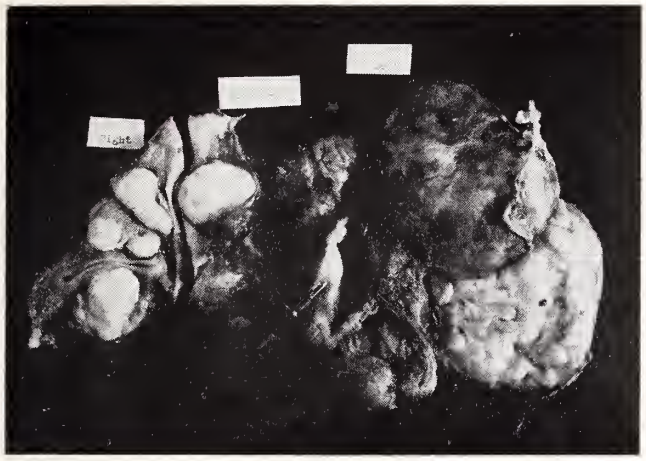


Figure 1. Leiomyomas distorting and compressing endometrial cavities of both uteri. One ovary in center of specimen.

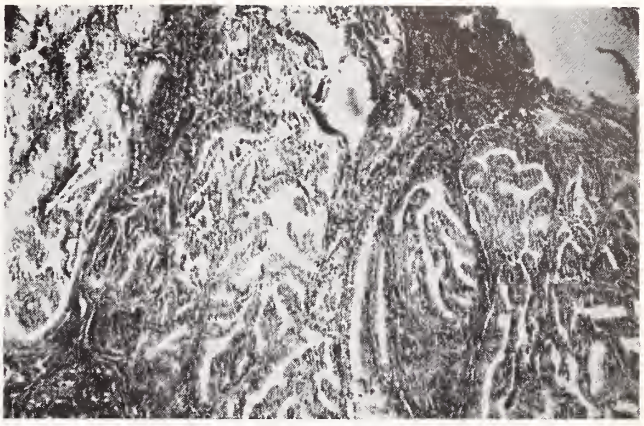


Figure 2. Moderately well differentiated adenocarcinoma of the endometrium found in the left fundus.

6 cm. in diameter (Figure 1). The left uterus contained a small endometrial polyp. On microscopic examination a circumscribed focus of moderately well differentiated endometrial adenocarcinoma was discovered in the left fundus (Figure 2).

Both ovaries were atrophic and the left tube and ovary were the site of endometriosis. The left fallopian tube was chronically inflamed and showed salpingitis isthmica nodosa. In consultation with the radio-therapist, it was agreed that no immediate additional therapy was indicated. The patient was discharged improved with a primary diagnosis of adenocarcinoma of the endometrium in the left body of a didelphic uterus.

COMMENT

The abnormality demonstrated in this case is the type generally accepted as uterus didelphys and described by Jones[5] in his classification. Renal anomalies have been frequently reported[5, 6, 7] as a feature in uterocervical abnormalities, but none were present in this patient. A review of the literature did not reveal any significant predilection of endometrial carcinoma for either right or left fundus of a divided uterus. It was also noted that no instance of associated sarcoma was described, although leiomyomata were not unusual. The case of a chorioadenoma destruens in uterine abnormality described by Kern[8] holds a singular position. It was not included in the compilations of either Duncan[3] or Nicholson.[4] Should that case be included, the total reported number of endometrial malignancies in congenital abnormalities would be 54.

The question of an etiologic relationship between uterine anomalies and malignancy, if any, will not be enlightened by this paper. However, it is hoped this report will assist other investigators in their continuing assessment of these unique pathologic entities.

SUMMARY

A case of adenocarcinoma of the endometrium in one horn of a uterus didelphys is described. This is the fifty-third report in the literature of endometrial carcinoma associated with congenital uterine anomalies.

ACKNOWLEDGMENT

We gratefully acknowledge the assistance of Mrs. Isaac Neuman in translating the Spanish reference.

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Treatment of Traumatic Paraplegic Patients by Localized Cooling of the Spinal Cord

GASTON J. ACOSTA-RUA, M.D.
Iowa City

Advances in medical treatment, neurosurgical techniques and nursing care have markedly improved the outlook for traumatic paraplegic and quadriplegic patients. Although there has been a significant decrease in the early mortality and a reasonable life expectancy for the average paraplegic patient, still the present methods of treatment are not effective in producing a functional recovery.

Edema of the spinal cord occurs in every major spinal cord injury and frequently produces neurological symptoms and signs which are often associated with mechanical obstruction of the spinal canal. In some patients, the anatomical integrity of the spinal cord is preserved, but the edematous injured cord may cause what can be considered an ischemic transection.[6]

Reversibility of this reaction and functional recovery may be possible if the compression factor is removed and the secondary edema is prevented or its effect minimized.

The protective effect of hypothermia on the central nervous system has been well documented by clinical and experimental evidences.[2-5, 7] The technique of local extravascular hypothermia of the spinal cord has been described by Negrin in the human and by White *et al.* in the experimental animal.

Albin *et al.* reported that experimental spinal cord injury in monkeys can be well tolerated if local hypothermia is instituted within four hours following the injury.[1]

Negrin reported two cases in which spasticity of the lower extremities, secondary to cord injury, was temporarily improved following localized hypothermia. However, the usefulness or harmfulness of this procedure had not been definitely demonstrated.

This report concerns the application of localized cooling of the spinal cord with functional recovery in two patients with traumatic paraplegia.

CASE REPORTS

Case No. 1—K.D. 67-7360

A 17-year-old male was involved in a motorcycle accident the evening of May 30, 1967. He sustained injuries to the head, back and right leg. The patient was admitted to the local hospital and a fracture dislocation of the right ankle was treated. On admission, he was poorly responsive but able to move both legs. The next day the patient was paraplegic and unable to void. Roentgenograms showed a fracture dislocation of T-12, L-1. The patient was transferred to University Hospitals at 1:00 a.m. on June 1 at which time he had a flaccid paraplegia. He had an indwelling catheter and the anal sphincter was flaccid. However, he had preservation of pain sensation in both lower limbs. An emergency decompressive laminectomy at T-12, L-1 and L-2 was performed. The dura was opened and the spinal cord was found to be slightly swollen. The exposed cord segment was cooled for exactly three hours. The same day of the operation, the patient was able to move the left foot. There was no change in the sensory examination. During the following days he showed progressive improvement of motor function. The wound healed well. On discharge (July 19, 1967), he had voluntary movement of all toes, plantar flexion and dorsiflexion of both feet against gravity and moderate flexion and extension of both knees. On the last follow-up examination in April, 1968, the patient was ambulatory although with a foot drop on the right and mild atrophy of the entire right lower extremity. He had good control of bladder and bowel function.

This preliminary report is by Dr. Acosta-Rua, a resident in the Division of Neurosurgery of the Department of Surgery at the U. of I. College of Medicine.

CASE NO. 2—M.E. 68-1418

A 21-year-old male was admitted to University Hospitals on January 28, 1968 approximately two hours after being involved in an automobile accident. Immediately after the accident he was unable to move his lower extremities. On examination, he had a flaccid paraplegia and lower areflexia. Sensory examination revealed hypalgesia below D-10 level with sacral sparing. Position and vibratory senses were intact. Roentgenograms revealed a compression fracture of T-8 and T-9 vertebrae. A lumbar puncture revealed a pressure of 260 mm. H_2O and there was evidence of block on Queckenstedt's test. An emergency decompressive laminectomy of T-7, T-8 and T-9 was performed. Following the opening of the dura, the exposed spinal cord segment was cooled in the same fashion as in Case No. 1. The same day the patient was able to move the right toes. On the second postoperative day he had flexion of the right foot. The sensory examination was unchanged. Motor function progressively improved. The wound healed well. On discharge (March 9, 1968), the patient was ambulatory. Graphesthesia was impaired in both lower extremities and there was hyperreflexia with bilateral Babinski signs.

TECHNIQUE

After decompressive laminectomy, the dura was opened and the exposed segment of the spinal cord was cooled with a continuous recirculated solution of isotonic saline at a flow rate of 80 ml. per minute, using a Brown heat exchanger and Roller pump. The temperature of the solution in the wound area was two degrees Centigrade. The spinal cord segment was cooled for exactly three hours. The dura was left open, the spinal cord was covered with strips of Gelfoam and the wound closed in layers (Figures 1 and 2).

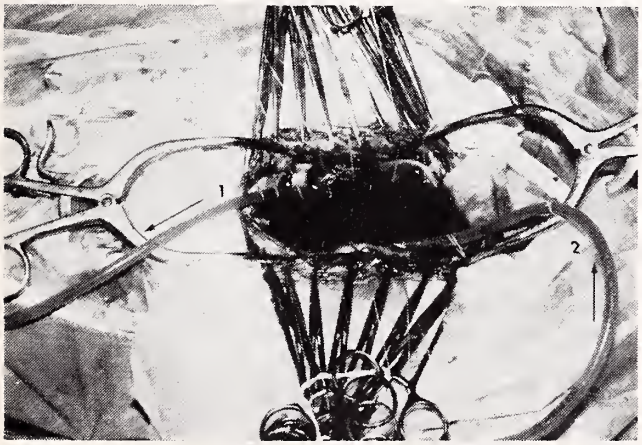


Figure 1. System for spinal cord cooling, using the surgical area as a reservoir. (1) outflow; (2) inflow.

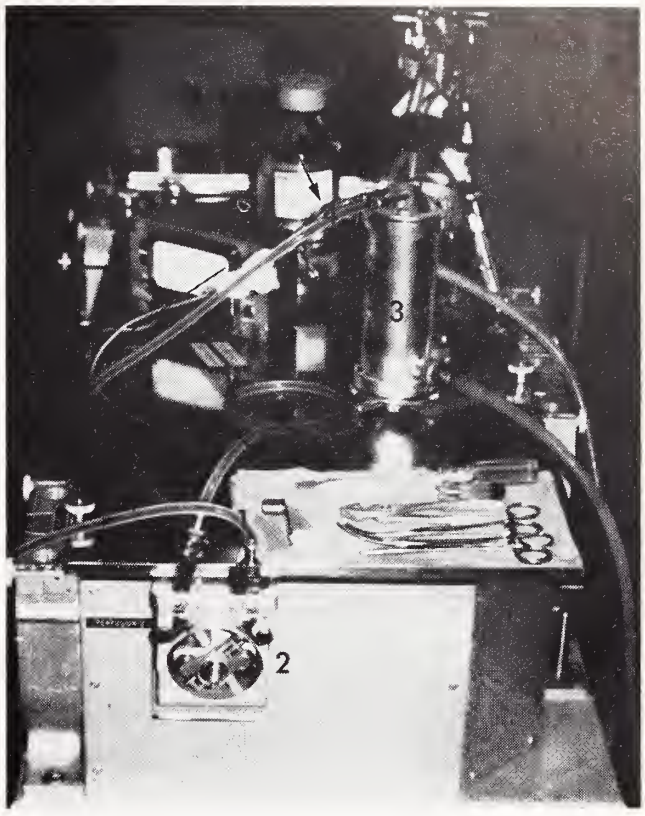


Figure 2. Cooling unit. (1) outflow; (2) roller pump; (3) heat exchanger; (4) inflow.

CONCLUSION

It is impossible to say whether or not these patients would have recovered spontaneously. Decompressive laminectomy may have helped recovery; however, the effect of spinal cord cooling is unknown.

Extravascular local hypothermia to the traumatized cord may have a protective effect; it does not seem to produce further damage to the spinal cord, and it may contribute to the recovery of spinal cord function.

Cooling of the traumatized spinal cord, provided it is not anatomically transected, should be investigated further. It is suggested that the earlier the cooling is done after the injury, the better may be the expected results.

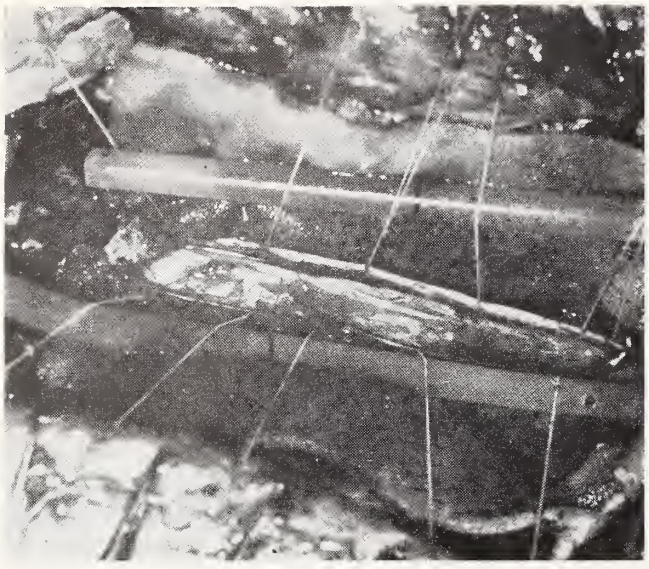


Figure 3. Case No. 3 before cooling procedure.

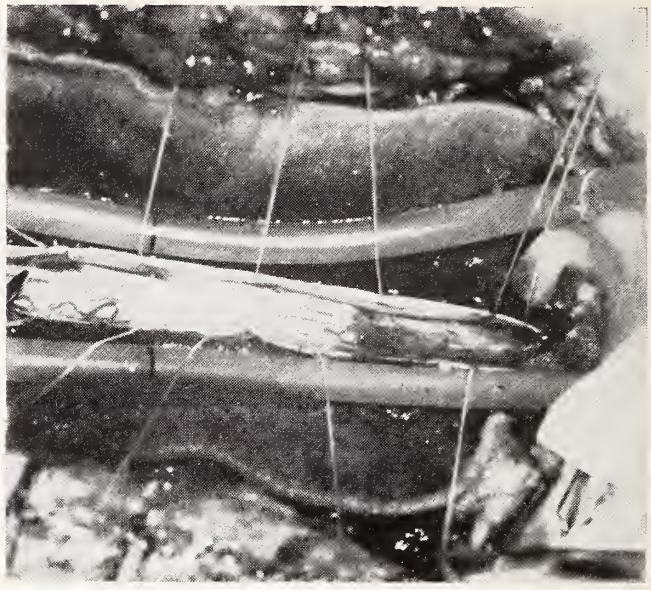


Figure 4. Case No. 3 after cooling.

ADDENDUM

Since this paper was submitted for publication, we have treated two other patients by this method. Case No. 3 is a 19-year-old female who sustained fracture dislocation at T5-T6, with a complete neurological deficit below the level of the lesion. One month after the treatment, this patient still remains paraplegic (Figures 3 and 4).

The Case No. 4 is a 21-year-old male who fell off a motorcycle and sustained fracture dislocation at T-6, T-7, also with a complete neurological deficit. Two weeks following the treatment the patient shows no evidence of improvement.

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U. of I. Cardiology Division Offers New Program

A new postgraduate program for Iowa physicians has been established by the Cardiology Division of the University of Iowa College of Medicine. The program is intended for practitioners who wish to re-acquaint themselves with one or more aspects of cardiologic practice.

The program is to consist of a one-week clinical experience at the University. Physicians who participate will meet the members of the cardiology staff and join them in patient care activities in the wards and clinics of the University and VA Hospitals. They will also attend cardiology conferences.

Participants may elect to pursue in depth a field of special interest. Options here include: 1) EKG interpretation, 2) auscultation of the heart, 3) interpretation cine-angiograms, 4) intra-atrial electrocardiography, 5) cardiovascular physiology as reflected in the cardiac catheterization laboratory, and 6) cardiovascular pathology.

One physician will be accepted for the program each month. The course will cover a five-and-a-half day period and will provide 44 credit hours from the AAGP. The registration fee is $100.

Physicians interested in the course may contact Robert J. Luchi, M.D., 9W-81 Laboratories, Veterans Administration Hospital, Iowa City, Iowa 52240. Dr. Luchi's telephone number is 319-338-0581, Ext. 335.

Seven-Year Review of Maternal and Perinatal Deaths

MADELENE DONNELLY HEALY, M.D.
Clear Lake

THIS IS A PRELIMINARY REPORT on maternal deaths in Iowa for the seven-year period from 1962 through 1968. The report includes available information on perinatal mortality for these same years.

During this period there was a definite downward trend in the number of births in Iowa (from 61,705 in 1962 to 47,492 in 1968). The average maternal death rate during these years was 2.7 per 10,000 live births, going as low as 1.7 in 1965 and 1968 and as high as 3.4 in 1964.

In the 10-year period preceding this the average maternal death rate was 4.0 per 10,000 total births, going below 3 in 1957 and 1960 and above 5 in 1953, 1954 and 1955.

Perinatal studies were not done before 1953. In 1953 the perinatal death rate was 30.0 per 1,000 total births. This decreased a little each year and the 10-year average was 28.6. The average perinatal death rate for the present seven-year period was 26.4 (Table I). There is very little variation in these rates from year to year. The perinatal death rates include (1) all live born who die in first 28 days, regardless of birth weight, and (2) all fetal deaths after the twentieth week of gestation.

No attempt has ever been made to review these deaths on a state or area basis. Some hospitals study those cases related to their institutions. Statistics on perinatal deaths, however, are reviewed annually by the Division of Maternal and Child Health of the State Department of Health.

When only perinatal deaths are considered sometimes missed is the fact that in some areas there are an inordinate number of fetal deaths. Table II compares perinatal death rates with the conventional neonatal and fetal death rates. There does appear to be a little more fluctuation in the fetal death rates (10.9 to 12.0) than in the neonatal (14.6 to 15.4) and perinatal (25.4 to 26.7).

One rate that must be noted is the incidence of prematurity (Table III). In arriving at incidence of low birth weight infants, the 2500 gm. birth weight is used as a dividing point. Iowa has always had a low rate of prematurity. Until 1962 prematurity was always well under 6 per cent. During these past seven years it has increased to an average of 67.4 per 1,000 total births, ranging from 60.7 to 69.5.

When we compare the death rates of low birth weight infants with those rates for infants over 2500 gms. we easily see the concern for increase in ratios of prematurity (Table IV). Less than one infant per 1,000 die in the larger group while in the low birth weight group about 250 per 1,000 die, or 25 per cent of the smaller babies.

To return now to maternal deaths, I personally feel that all maternal deaths are not reported. Less than 50 per cent of the deaths reported are reported by physicians or hospitals, even though there is a regulation which requires that any possible maternal death be reported within 48 hours. The rest are identified by the Health Department staff in two ways. First, all deaths which give any cause relating to a pregnancy (where pregnancy, delivery or postpartum are mentioned), are automatically referred to the Division of Maternal and Child Health for follow-up.

As a final step all female deaths between 14 and 50 years of age are alphabetically listed and compared with alphabetical birth lists. When a last name matches, further search is made as to name of father and mother, address, name of hospital, name of attending physician, etc. There is nothing on the death certificate to indicate relationship to a pregnancy—but

This article was prepared by Dr. Donnelly from her experience as chief. Maternal and Child Health Division, State Department of Health.

TABLE I

IOWA MATERNAL DEATH RATES AND PERINATAL DEATH RATES

Year	Maternal Death Rate Per 10,000 Live Births	Perinatal Death Rate Per 1,000 Total Births
1962	2.1	25.7
1963	2.6	26.7
1964	3.4	26.1
1965	1.7	25.9
1966	2.2	25.4
1967	1.9	26.6
1968	1.7	26.5
Total for seven years	2.25	26.4

TABLE II

IOWA PERINATAL DEATH RATES WITH CONVENTIONAL NEONATAL AND FETAL DEATH RATES

Year	Perinatal Death Rates Per 1000 Total Births	Fetal Deaths Per 1000 Live Births	Neonatal Deaths Per 1000 Live Births
1962	25.7	11.4	14.6
1963	26.7	11.9	15.1
1964	26.1	10.9	15.4
1965	25.9	11.3	14.9
1966	25.4	10.9	14.7
1967	26.6	12.0	15.0
1968	26.5	11.7	15.1

TABLE III

IOWA PERINATAL DEATH RATE COMPARED TO INCIDENCE OF PREMATURITY

Year	Perinatal Death Rate	No. Premature Per 1000 Births
1962	25.7	63.0
1963	26.7	60.7
1964	26.1	64.4
1965	25.9	67.1
1966	25.4	69.5
1967	26.6	68.0
1968	26.5	66.8

TABLE IV

IOWA PERINATAL DEATH RATE (TOTAL) COMPARED TO THOSE OF PREMATURE AND MATURE INFANTS

Year	Death Rate Per 1000 Total Births		
	Perinatal	Premature	Mature
1962	25.7	252.1	8.8
1963	26.7	282.3	9.4
1964	26.1	298.5	9.4
1965	25.9	251.8	9.1
1966	25.4	243.2	8.4
1967	26.6	249.1	9.6
1968	26.5	244.9	9.4

TABLE V

IOWA MATERNAL DEATH RATE BY AGE OF MOTHER

Age of Mother	Maternal Death Rate Per 10,000 Live Births
-20	1.21
20-24	2.00
25-29	1.35
30-34	3.48
35-39	4.82
40+	6.80

TABLE VI

IOWA MATERNAL DEATH RATE BY PARITY OF MOTHER

Parity of Mother	Maternal Death Rate Per 10,000 Live Births
0	1.49
1	1.00
2	0.92
3+	3.55

TABLE VII

IOWA MATERNAL DEATH RATES BY CAUSE

(4 Leading Causes)

Cause	Maternal Death Rate Per 10,000 Live Births
Hemorrhage	0.67
Toxemia	0.18
Infections	0.509
Embolic Phenomenon	0.40

TABLE VIII

IOWA MATERNAL DEATH RATE BY CAUSE AND BY AGE

Age	Cause Rate Per 10,000 Live Births			
	Hemorrhage	Toxemia	Infection	Embolism
-20	0.202	0.202	0.202	0.000
20-24	0.500	0.071	0.643	0.420
25-29	0.415	0.103	0.103	0.207
30-34	0.969	0.193	0.581	0.969
35-39	2.226	0.742	1.113	0.371
40+	2.266	1.133	2.266	1.113

TABLE IX

IOWA MATERNAL DEATH RATE BY CAUSE AND BY PARITY

Parity	Cause Rate Per 10,000 Live Births Hemorrhage	Toxemia	Infection	Embolism
0	0.399	0.120	0.925	1.613
1	0.299	0.000	0.308	0.806
2	0.099	0.240	0.154	1.613
3+	15.964	0.720	0.925	8.069

reviewing the matching birth certificate gives plenty of reason for investigation of the case.

Table V shows the maternal death rate for the various age groups of mothers. The death rate increases rather steadily. Although comparatively few mothers have babies after age 40, their death rate is three times the average. Likewise in Table VI we see that although mothers of first babies have a higher death rate, the greatest increase is in mothers having three or more deliveries.

The total number of maternal deaths reviewed was 84. Twenty-five of these were due to hemorrhage, 7 toxemia, 19 infections, and 15 embolic phenomenon. The remaining 18 were caused by: cerebral accidents 6, cardiac or circulatory failure 3, chorio-epithelioma 1, suicide 1, acute hepatitis 1, anesthesia 1, hydatid mole 1, heat stroke 1, schizophrenia 1, cause undetermined 2. The rates for the four leading causes of death are seen in Table VII.

In the last two tables the rate of death by cause of death is calculated by age and parity of patient. The rates for almost all causes sharply increase with age and parity.

Although these meager figures do not give us a great deal of argumentative material, two firm conclusions may be drawn:

1. If maternal death studies are to be continued for educational purposes, they can only be done by stronger cooperation on the part of the medical profession. More responsibility must be borne by the practicing physician.

2. From the studies done, certain age and parity groups definitely fall in the high risk groups and every pregnant female in these groups should receive specialized and meticulous prenatal care to prevent development of conditions which might become complications leading to death.

IRMP Initiates Medical Literature Network

A new medical literature network has been established by the Iowa Regional Medical Program to provide Iowa physicians and allied health professionals quick access to a wide selection of medical resource material.

The IRMP program has a twofold objective: (1) to make a broad range of medical literature available to individual physicians via a coordinated system which assures prompt delivery, and (2) to aid hospital libraries by offering guidance and training to those in charge.

An IRMP Health Science Library Advisory Committee has been formed to coordinate the program. The committee is headed by Robert Cryder, director of the Medical Library at the U. of I. College of Medicine. Headquarters for the medical literature network is the State Medical Library, East 12th and Grand, Des Moines 50322. Mrs. Marion Samo is the acting State Medical Librarian.

Literature requests of a pressing nature will be accepted by telephone. Physicians may call the State Medical Library—(515) 281-5772—and the call will set into motion the services of the medical literature network. Through the network, the inquiring physician or other health professional will have made available to him the resources not only of the State Medical Library, but also those of the U. of I. College of Medicine, Iowa State University, the state's three VA Hospitals and the College of Osteopathic Medicine and Surgery.

Should none of these sources have the materials desired, the network will then call upon the Regional Library of the National Library of Medicine to provide the articles or other materials. Copies of the desired material will be provided at no charge, along with bibliographies on specific topics.

Inquiries regarding the hospital library activity may be forwarded to the IRMP Health Science Library Advisory Committee in care of Mr. Cryder.

President's Page

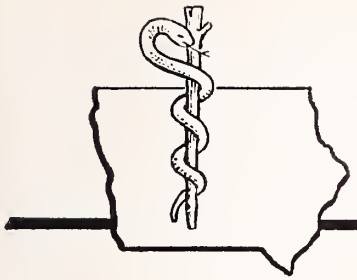


The socio-economic adjustments of this era have been of significant proportion. They encompass, obviously, the delivery of health care. As deliverers of health care, we must be the leaders; we must be the ones to make adjustments in our system.

Hardly any of us have lived in a non-work society where planning for the future is a nonentity. The task we face now is one of planning; in this consumer-oriented era we must preserve our heritage and blend with it new, well-tested approaches. Our concern must be for the consumers, our patients.

I pledge in 1970-71 the Society will lead, not follow.

President



Editorials

SPACESHIP EARTH

Reprinted in the July-August 1969 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS is the Martin Memorial Lecture given by Father William G. Pollard before the Clinical Congress of the College. Father Pollard, doctor of philosophy, physicist and priest, is the executive director of the Oak Ridge Associated Universities and priest associate of St. Stephen's Church, Oak Ridge, Tennessee.

It is the belief of Father Pollard that man—right now—in the Twentieth Century—is, for the first time, approaching the fulfillment of the Lord's injunction to "be fruitful and multiply and fill the earth and subdue it; and have dominion over the fish of the sea, and over the birds of the air, and over the cattle, and over all the earth." The catch seems to be, however, that the fulfillment of the injunction has created some rather imposing problems. It is a matter of conjecture, of course, as to whether the Lord had anticipated such a perplexing turn of events.

Father Pollard believes that we only have a few more years, until the end of this century as a matter of fact, to "accomplish all that must be accomplished for man to continue his existence on the planet at any reasonable standard of living." To do so, he says, we must achieve technological and social changes far beyond those of previous years. Yet, up to a point, he is not pessimistic, and he suggests that first of all we recognize the realities of our situation. His most useful image for this purpose is the analogy of the earth as a spaceship carrying man on a "long journey through space." With this in mind, he enumerates the fundamental requirements of a spaceship, and in some detail discusses their application to our situation here on earth and their means of achievement.

The following is a brief summary of those requirements as listed by Father Pollard, and his thoughts relative to their attainment:

1. *An adequate source of energy:* Nuclear fuels are almost limitless, and because nuclear power will be necessary, it inevitably will be widely available.

2. *An adequate food supply or means of production:* Technology will solve the food problem in the long run, but not soon enough to prevent "a famine of catastrophic proportions by the early 1970's . . . a calamity unparalleled in human history involving death by starvation for numbers running into the hundreds of millions."

3. *Adequate air and water, of proper purity:* Nuclear desalinization of seawater, diversion of "wasted water," and tapping the immense subterranean reservoirs of fresh water under the Sahara will provide an adequate water supply both for consumption as well as for the irrigation projects that are so essential to meeting the food requirements.

4. *A proper means of reprocessing or disposing of wastes:* Pollution control, both of air and water, is even now almost within our grasp, the problem basically being more political, social, and economic than technical.

5. *A unified, mutually compatible crew:* This seems almost unobtainable on the spaceship earth, yet there is reason for guarded optimism that a "balance of power," a "balance of wealth," and a "balance of ideology" will ultimately be reached.

Now we come to the crunch—the final requirement:

6. *A stable spaceship population:* In the words of Father Pollard, man "must stop being fruitful, and cease further multiplication." And

Editorials continued...

soon! He acknowledges that no other requirement of our spaceship earth "calls for such a deep-seated readjustment in long-established religious, moral, and social patterns, or is more resolutely resisted by mankind."

What can these religious, moral, and social readjustments be that he refers to? He does not elaborate, but one could guess that he may be alluding to mandatory birth control, abortion, euthanasia, and possibly some form of mercy killing of the incompetent, the retarded, the insane, the aged—all those who are said to be non-contributing members of society. Yet even if he did not have these considerations in mind, it is certain that others have, or will in the future. To have a stable population no one can be born until someone dies, or, in more practical terms, each birth must be balanced by someone's death. And how do you accomplish that? It is a fair question and a frightening thought, and generalities should not be allowed to gloss it over.

As our population problems descend on us, however, it might be well if we looked to some solution other than the destruction of life. Perhaps we should look up and consider the fact that we are no longer bound to our spaceship earth, that we are now, in truth, by virtue of our space technology, creatures of the universe. Could it be that the biblical injunction requires that we multiply and fill the *universe* and subdue it, not just the earth? Maybe we are not, at this time in history, already at the point of "fulfilling the purpose asserted for man"—near the end of the road, as Father Pollard suggests. Perhaps we are only at the beginning.

DANIEL F. CROWLEY, M.D.

IMPORTANCE OF ADVISING THE PATIENT

In a significant paper entitled, "Early Detection of Disease in Young Men," Dr. N. Thomas Connally, George Washington University School of Medicine, points out that between 1900 and 1954 the average life expectancy in the United States increased from 44 to 66 years.* But in the decade 1954 to 1964 male life expectancy did not change and for women it rose less than one year. Statistics show the male death rate in middle age (or the years remaining after the age of 10 years) is such to place the United States thirty-second among the nations of the world.

During the decade when life expectancy remained stationary in this country, the excellence of medical education and research was recognized throughout the world. Many new and sophisticated therapeutic measures were introduced for the benefit of patients suffering from what heretofore were considered incurable diseases. Also in this decade expenditures for the national health increased to 45 to 50 billion dollars a year. Dr. Connally ascribes the failure of health statistics to improve to a focusing of our health effort on the end stage of disease and to the neglect of emphasizing preventive medicine in the early stages of degenerative diseases.

To illustrate his thesis the author presents a fictional case, a 33-year-old securities salesman seen for a routine annual physical examination. His father died at age 56 of myocardial infarction. His mother, age 61, is in good health. The patient states he is in good health and except for a weight gain of about five pounds during the last year, he has no complaints. In high school and college he was active in athletics, but since college his physical activity has been limited to 18 holes of golf every other weekend during the spring and summer. He drives to and from his office and most of his business is conducted over the phone.

The patient has smoked one and one-half packages of cigarettes per day for 14 years. He is accustomed to a highball or beer before dinner. He weighs about 30 pounds more than he did when he stopped playing football at

* Connally, N. T.: Early detection of disease in young men. MED. ANN. DIST. COLUMBIA, 38:672-676, (Dec.) 1969.

Editorials continued...

age 20. He has never restricted his diet except to cut down on calories for brief periods several years ago. His breakfast consists of two eggs, bacon or sausage and a glass of whole milk. Dinner at night consists of beef or pork as the main course.

His height is 71 inches; his weight, 209 pounds. His blood pressure is 140/95; his pulse rate, 80. Except for moderate obesity and a modestly elevated blood pressure, the physical examination is otherwise quite normal. Laboratory studies are within normal limits except for a serum cholesterol of 266 mg. per 100 ml. and serum triglycerides of 192 mg. per 100 ml. Chest x-ray and electrocardiogram show no abnormalities.

The author in reviewing the patient's history, physical examination and laboratory studies finds it difficult to diagnose any definite disease entity. However, he feels the man is not healthy and typifies the number one health problem in this country, i.e., a young man who has not learned to take care of himself and who probably has two or more preclinical diseases.

The first question raised is how often should an individual undergo a periodic health examination. According to the author, we do not know the answer. The medical literature contains many articles noting a favorable mortality record among a group undergoing periodic health examinations compared to a control group. However, just what studies should be carried out in such an examination await the outcome of further well-controlled studies. With the introduction of automation, which permits more tests at less expense, the number and kind of tests which should be performed may be clarified.

One approach to the problem of disease in young men is based on an understanding of the natural history and the pathogenesis of certain major diseases. Some of these diseases can be detected early and the pathologic process reversed. Based on this premise, data compiled in prospective studies of the value of physical examinations will not only take into account what studies were done but what the physician and the patient did about the tests, and whether the patient changed his habits as a result of the consultation.

Dr. Connally emphasizes that one disease in which preventive advice is most important is arteriosclerotic coronary artery disease. In the United States cardiovascular disease, in general, accounts for 55 per cent of deaths, and 30 per cent of all deaths are due to coronary artery disease. Of the approximately 700,000 deaths per year among people under 65, about 250,000 or 35 per cent are due to cardiovascular disease, and 150,000 or about 22 per cent are due to coronary atherosclerosis. The average adult male has about one chance in five of having a clinical coronary heart disease before age 60, and of these about one-half will be dead within five years.

It is now generally recognized that if national health statistics are to improve there must be a concentration on primary prevention. This involves advising and treating the young man before he has a myocardial infarction, and it involves preventive efforts directed toward the major coronary risk factors. The Framingham study and numerous others have made it clear that the major risk factors are: (1) an increased level of serum lipids; (2) increasing levels of blood pressure; (3) cigarette smoking, and (4) obesity. A man who possesses one or more of these risk factors stands a 2- to 10-fold greater chance of developing coronary heart disease than the man who has none of these factors.

Present in the hypothetical case of the 33-year-old man are all of the risk factors, at least to some degree. They are present despite the fact he has no complaints and considers himself a well man. The physician should recognize (1) the patient is not a well man; (2) that he probably has two or more preclinical diseases, and (3) that he is representative of the greatest health problem in this country—a young man who has not learned how to take care of himself.

In his concluding paragraph Dr. Connally states that the physician in the discussion associated with the periodic health examination should convince the patient to do three things: (1) to reduce the amount of saturated fat in his diet; (2) to stop smoking, and (3) to lose weight. This accomplished, the patient's chances of surviving middle age will be greatly en-

Editorials continued...

hanced. The author emphasizes that the most important variable in the routine physical examination is the persuasive skill of the physician rather than the number of expensive tests performed. Good advice and a few well chosen tests can do a great deal for the patient's longevity. Dr. Connally says that, "careful attention to advising the patient after his periodic physical examination represents the most productive use of a physician's time."

TETANUS AND POLIO IMMUNIZATIONS

The 1970 "Report of the Committee on Infectious Diseases" has been released by the American Academy of Pediatrics. It seems important to review some of the Report's provisions regarding immunization procedures and schedules, especially against tetanus and poliomyelitis, because of the apparent variation one confronts when serving people who have moved from another locale.

Protection against tetanus perhaps causes as much concern in the minds of Iowa medical practitioners as any other immunization. Active immunization is indicated for all infants and children. Such routine primary immunization is conveniently carried out using DPT adsorbed. The depot antigens are preferred to combined fluid toxoids and pertussis vaccine because they are more immunogenic. For complete immunization, three injections are given at monthly intervals starting at two months of age, and a fourth injection at approximately 15 months of age. The injections of depot antigens should be deep into the muscle mass at a different site with each of the primary injections. Interruption of the routine immunization schedule because of intermittent disease, missed appointment, etc., causing a delay between doses, does not necessitate starting the series again regardless of the interval elapsed.

Variations of the routine schedules are necessary for infants with neurologic disorders and those who display an untoward reaction to a previous DPT injection. Fractional doses may be necessary.

The routine "booster" injections following the 15-month injection should be at 4-6 years of age, again at 12-14 years of age and then every 10 years. At 4-6 years the material is again the DPT as given earlier. At 12-14 years and thereafter, it is recommended use be made of the adult type of combined tetanus-diphtheria toxoid (Td) which contains a lower concentration of diphtheria toxoid. The standard diphtheria-tetanus (TD) may cause severe reactions in older children and adults.

Perhaps the greatest confusion arises in the question of booster injections and recall injections at the time of injury. It has been very well demonstrated in military situations that the immunity conferred by tetanus toxoid is extremely long lasting, and that frequent recall injections are associated with an increased incidence of reactions. Annual booster injections are "unwarranted and should be discontinued." It is recommended that routine booster injections after age 12-14 years should be every 10 years.

For puncture wounds, animal bites, encrusted lacerations and wounds likely to be contaminated with soil or manure, give Td or tetanus toxoid with adjuvant unless the victim is known to have had such an injection within the year. Thus, it would seem that every break in the skin does not require another booster injection as has sometimes been suggested.

Another area of confusion is in the use of oral poliomyelitis (Sabin) vaccine. Three doses of trivalent vaccine are recommended for all infants, the first at approximately two months of age, and the second and third at about 6-8

week intervals thereafter. A fourth dose of the trivalent vaccine is then to be given at approximately 15-18 months of age. A single dose of trivalent vaccine is desirable again on entrance to school for children who have had the previous immunizations in earlier life.

Immunity following a full course of oral poliomyelitis vaccine seems to persist for a number of years in much the same way as immunity follows a natural infection. Therefore, local conditions would dictate the need for booster doses beyond the school entrance age.

MARION E. ALBERTS, M.D.

URGE ECG TO DETECT ASYMPTOMATIC INFARCTS

We are prone to think of initial heart attacks as dramatic events characterized by severe pain during which the patient experiences a fear of impending death. A recent report from the Framingham study prompts a modification of this accustomed concept. According to the report, nearly a fourth of the initial nonfatal heart attacks during the 14-year study were silent infarctions which went unrecognized by both patient and physician.

The report by W. B. Kannel, P. M. McNamara, M. Feinleib, and T. E. Dawbeer considers the frequency, outcome and characteristics of patients who developed unrecognized myocardial infarctions in a population of 5,127 men and women over a period of more than 14 years.* All persons in the study, initially free of coronary heart disease, had cardiovascular examinations and electrocardiograms at two-year intervals. In addition, hospital admissions were monitored, and detailed information was procured concerning each patient with a diagnosis of myocardial infarction.

During the 14-year period 172 men and 42 women developed unequivocal evidence of myocardial infarction for the first time. Of these, 151 men and 37 women had ECG evidence of myocardial necrosis. And among those with ECG evidence of myocardial infarction, 11 women (30 per cent) and 33 men (22 per cent), the infarction was completely unknown to either the patient or his physician. About half of these were *silent* and the remainder were so atypical that neither the patient nor the physician considered the possibility of infarction.

The persons in the study were between 30 and 79 years of age and the average age of those in the unrecognized infarction group was almost identical to that in the recognized group.

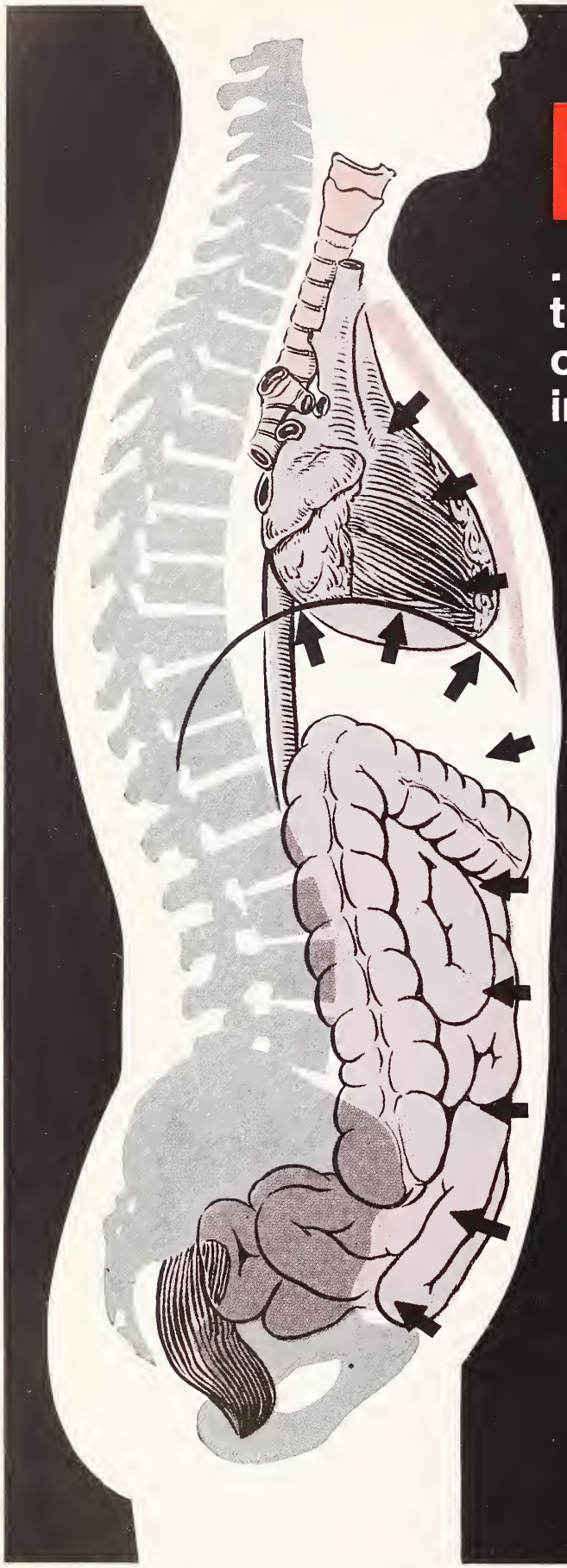
The study revealed that the proportion of unrecognized infarctions was five times as frequent among those without antecedent angina as among those with prior symptoms of angina pectoris. However, persons with unrecognized infarctions were found to develop anginal distress after their infarctions as frequently as did those with symptomatic recognized infarctions.

It was found that diabetics had almost twice as many of their infarctions recognized as did nondiabetics. Hypertensive patients had more of their infarctions recognized (33 per cent) than did normotensive patients (19 per cent). Rather surprising was the finding that persons with antecedent ECG abnormalities appeared to be more likely to have an unrecognized infarct.

In a consideration of the prognosis of those with an unrecognized infarct, those detected at a routine two-year check-up, it was found that the overall survival was no better than in those with a recognized symptomatic infarction. The unrecognized infarct must be looked upon as far from innocuous.

The authors conclude their report by stating that the frequent periodic routine use of ECG is at present the only feasible method for detecting asymptomatic infarction. They further emphasize that the essential factor is a high index of suspicion. They urge routine periodic ECG's for vulnerable persons, particularly those with diabetes, hypertension and ECG abnormalities. Suggestive complaints in such persons are an indication for prompt and serial examinations.

* Kannel, W. B., McNamara, P. M., Feinleib, M., and Dawbeer, T. E.: Unrecognized myocardial infarction; 14 year follow up experience in Framingham study. GERIATRICS, **25**: 75-86, (Jan.) 1970.



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*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice,* 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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University Hospitals DRUG LETTER

Degerming Solutions for Surgical Scrub and Skin Preparation

JOHN A. GIUS, M.D.
Iowa City

MANY PREPARATIONS and techniques are available for surgical cleansing and degerming of the skin. There appears to be no clear superiority of one agent or one method over another. This has led to the use of many commercial preparations and a variety of practices. A College of Medicine committee consisting of Reginald Cooper, M.D., Daniel B. Thatcher, M.D., and the author have reviewed the problems and have made recommendations.

At the present time there is no satisfactory method for completely degerming the skin of the operative area or of the surgeon's hands. But near-complete degerming can be achieved by a combination of mechanical cleansing with soap and water followed by the application of an antiseptic solution. Usually, however, rapid regrowth of the bacteria remaining on the skin occurs, so that wound contamination with pathogenic organisms is likely to occur later unless other protective measures are taken. To further prevent contamination of the operative wound the field is often excluded from the surrounding skin by plastic adhesive drape and the surgeon's hands are covered with sterile rubber gloves.

SURGICAL SCRUB

There are a number of commercial surgical "soaps" which have been used. These include Phisohex and Septisol (both hexachlorophene "soaps"), Betadine (povidone—iodine), Ivory soap and, occasionally, tincture of green soap.

Hexachlorophene possesses both an immediate and prolonged degerming effect on the skin, especially when one scrubs repeatedly with hexachlorophene type "soaps." This substance is effective against gram-positive bacteria but is less effective against gram-negative bacteria and fungi. Hexachlorophene has also been impregnated into disposable polyurethane sponges for surgical scrubbing and these appear to have some advantages over conventional brushes.[1]

Povidone-iodine is a combination of iodine and solubilizing agents which slowly releases the iodine when diluted with water. A povidone-iodine soap is available at the scrub sinks and wards and in the operating rooms for skin preparation. This material is non-irritating. It also leaves a stain which can easily be removed with water and produces no hypersensitivity reactions. However, povidone-iodine is not currently recommended for ophthalmic surgery.

Dr. Gius is a professor of Surgery at U. of I. College of Medicine.

Iodine has long been considered a superior skin antiseptic which exerts its effect by direct halogenation and precipitation of protein. The action is rapid over a wide range of pH and a wide spectrum of microorganisms. Its antiseptic effectiveness is related to the concentration of free iodine but many of the preparations which were used in the past produced skin burns. Most of the "tamed" iodines (iodophors) have about one per cent "available" iodine which is released slowly. The degerming properties of the iodophors are somewhat less than those of the hexachlorophene soaps; and therefore, povidone-iodine is a second choice for the surgical scrub and preoperative skin preparation.

Price[2] has advocated the use of ethyl alcohol, 70 per cent (by weight) as a supplementary preparation for use with surgical soaps. Alcohol is a highly effective antiseptic and is also relatively non-irritating to the skin. A second alcohol solution is HIACA liniment which contains hexachlorphene, isopropyl alcohol and cetyl alcohol in water. The degerming efficacy of this solution was demonstrated experimentally by Dr. Walter Gower[3] and it has become a part of the routine surgical scrub in the Orthopedic Department. He recommended soaking the hands and arms for two minutes in a HIACA solution after a 10-minute scrub. It is necessary to dry the skin with a sterile towel before immersing the hands and the arms in the solution and after removal to permit the alcohol to evaporate.

SKIN PREPARATION

Phisohex and Betadine soaps are used for cleansing and degerming the skin preoperatively. In elective surgery the skin is shaved and cleansed with Phisohex the night before operation. Under these conditions a film of hexachlorophene is left on the skin where it exerts a prolonged antibacterial effect. The next morning the operative area is again cleansed with hexachlorophene soap. The final step in preparation of the operative field is the application of an antiseptic solution. This is carried out in the operation room just prior to application of the surgical drapes before operation.

For many years tincture of benzalkonium (Zephiran) was used for this purpose. The tincture contained a red dye which clearly defined the sterile field. There have been no adverse reactions to this preparation. However, it has been demonstrated that benzalkonium is not a very effective antiseptic[4] and whatever virtue it possessed as an antiseptic was probably due to the alcohol it contained. Likewise, aqueous benzalkonium was an inefficient antiseptic solution since it supported the growth of *Pseudomonas aeruginosa*. It should also be noted that benzalkonium is neutralized

by many substances and that it is one of several substances which neutralizes hexachlorophene. For these reasons, it was recommended that tincture of benzalkonium and aqueous benzalkonium no longer be used for purposes of skin antisepsis. Instead, ethyl alcohol to which a dye such as merbromin (Mercurochrome) or thimerosal (Merthiolate) is added can be used for the final step in skin preparation. The only exception to the use of an alcohol solution would be where cautery or another electrical appliance is needed during the operation. When this is the case, then povidone-iodine solution should be used for the final step in skin preparation. Povidone-iodine solution stains the operative field so that it can be clearly defined and also provides some degree of "tackiness" to the skin. This helps to seal the plastic surgical drape in place.

Because all tinctures and other preparations containing alcohol are potentially combustible, experts in fire prevention[5] have advised against their use when the possibility of explosion or burning exists. Therefore, when cautery or other electrical apparatus is used, alcohol solutions should not be used for skin preparation. Povidone-iodine can be substituted in most instances.

In the past, ether has been used for defatting the skin before application of adhesive tape dermatomes for cutting skin grafts, for enhancement of the adhesion of plastic drapes to the skin and also for a part of the skin preparation in certain instances. This is a dangerous practice because ether is highly volatile and inflammable and, if ignited, can cause serious injury to the patient or the operating room personnel. Therefore, ether is no longer used for skin preparation in the operating room. Trichloroethylene has been substituted for ether for this purpose. However, it must be used in small quantities, the bottle must be sealed immediately after use and any excess immediately mopped up and removed from the area. It is potentially a hepatotoxic agent.

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Iowa Association of Medical Assistants

Is Your Office Alive?

Several years ago, a very vibrant and talented speaker impressed me with the statement, "a medical office should be a living place." She explained that offices, as well as homes, benefit from the presence of living plants. They quickly transform a tired, dull office into a pleasant and alive one.

It was many years ago that the idea of raising plants indoors originated and, even though today's artificial plants are amazingly realistic, it is still more gratifying when patients admire the "real thing" and launch into discussions about them. Don't let your enthusiasm for a little office "greenery" be dampened by scholarly-sounding treatises with botanical terms, by chemical formulas for soil maintenance, or by formidable lists of possible pests. Plant culture is largely a matter of common sense. Inasmuch as most of today's offices have controlled temperature, humidity, and an abundance of light, plants really need very little attention.

Start with the common varieties of plants such as ivy or fern, or variations of philodendron and dieffenbachia. Incidentally, did you now the dieffenbachia is also called the "dumb plant?" It supposedly is capable of temporarily paralyzing a person's mouth and tongue if they chew a leaf! There are many species of cactus or, for a pretty blossom, you may consider such bulb flowers as narcissus, daffodil, amaryllis, or hyacinth. Or you might try producing indoor foliage by planting a whole sweet potato, carrot, beet or turnip; these can also be placed in water. The African violet is a great home favorite but needs a special amount of light and is not as easy to care for as some of the others mentioned.

The Asparagus sprengeri has always been a "must" in making up floral bouquets for it gives the arrangement that bit of "frilliness" needed to finish it off. Valuable as a cut specimen, it also serves as a beautiful year-round house plant. Sprengeri bears small white flowers which are followed by small red berries. It usually comes into bloom during summer and by Christmas the berries will be red, thus making it a pretty plant during the holiday season. It goes well in hanging baskets or on a tall stand; it does not like the hot rays of the sun.

A handsome addition to an entrance hall or corner is one of the Scheffleras. The Schefflera actinophylla from Australia and Java is often called the umbrella tree. The leaves are large, green, and palmately compound. The Schefflera digitata is a native of New Zealand and puts out seven to 10 leaflets on stems. The leaflets have yellowish veins and hairy margins. These need not be repotted often. If roots fill the container, biweekly feeding of liquid fertilizer will be beneficial.

Another interesting plant bearing spiny leaves and yellow flowers is the Aloe vera, commonly called the burn plant. Because of the thick, juicy-like mucilage contained in its leaves, it is said to be comforting and soothing to burns. Research reports state it is of particular importance in preparing medication for treatment of x-ray burns. This plant comes from Africa and belongs to the lily family. The spiny leaves of the stemless plant are grayish-green and often reach two feet in length. The little clusters of yellow flowers are borne on stems longer than the leaves. These plants will do well in the same pot for years without changing soil and will flower freely, too. Sooner or later, they become top heavy and require a larger and better balanced container. Bright, hot sun will bleach leaves and scorch tips of tender leaves. The plants are much prettier and easier to manage if they are not forced. Other members of the Aloes are used in warmer climates to decorate large buildings and large botanical gardens.

(Please turn to page 345)

1970
IAMA
Annual State Meeting
★
May 15-16-17
★
Holiday Inn
Waterloo, Iowa

INFORMATION FROM THE
IOWA HEART ASSOCIATION

Etiology and Pathogenesis of Hypertension

HARRIET P. DUSTAN, M.D.
Cleveland, Ohio

Hypertension is a major cardiovascular problem that is largely unsolved. However, there are a variety of drugs available for treatment which used singly or in combination reduce arterial pressure substantially. Such therapeutic effectiveness tends to obscure the fact that we actually know very little about the mechanisms of hypertension and the functional details of its natural history.

Hypertension is a symptom, not a disease. We know it to be associated with a variety of diseases, but these affect only a small number of patients so that most hypertension is without apparent cause. This condition is called *essential hypertension*. The term is an archaic misnomer because we now know that hypertension is not essential for anything. Long gone are the days when physicians believed elevated arterial pressure to be essential for maintenance of tissue perfusion.

Although elevated blood pressure, of itself, is a symptom, it is often associated with vascular diseases—arteriolar sclerosis or premature atherosclerosis. Arteriolar disease occurs more commonly in patients with severe diastolic hypertension, while premature atherosclerosis is usually a manifestation of long sustained arterial pressure elevation, even one of mild degree.

Hypertension can be classified in a number of ways according to: 1) the type of arterial pressure elevation—systolic, diastolic, or mixed; 2) the character of the elevation—labile or sustained; 3) severity of the associated vascular disease—mild, moderate, severe, or malignant (accelerated); or 4) etiology—renal, adrenal, cardiovascular, or essential. At our present level of knowledge, the etiologic classification is the most interesting. Not only does recognition of the various causes of elevated arterial pressure lead to more rational treatment, but also it gives an opportunity to study the mechanisms of hypertension.

The hypertensions associated with various diseases are called secondary. When none of these conditions is present, the hypertension is said to be primary. This term, like "essential," is a misnomer because each hypertension has a cause even though our knowledge is not sufficient to recognize it. Clearly, the more we have learned the more we have seen; for example, consider the types of hypertension recognized in the past 20 years. These include primary aldosteronism, renal arterial disease, and increased activity of the beta-adrenergic component of the sympathetic nervous system. Before these types were recognized, such patients were considered to have "essential" or "primary" hypertension.

The physiologic abnormalities found in hypertensives relate to the nervous control of the circulation, catecholamines, cardiac output and peripheral resistance, adrenal steroids, the renal pressor system and plasma volume. Evidence is accumulating that these factors do not operate alone, and it seems likely they make up an integrated system, one expression of which is elevated blood pressure.

When considering the etiology and pathogenesis of hypertension, it is an interesting exercise to see how these various factors are interrelated in the different types of hypertension. Of course, our present information is incomplete, but enough is available to make the exercise worthwhile.

The most frequently occurring secondary hypertensions now recognized are those associated with renal arterial disease and renal parenchymal disease, pheochromocytoma, primary aldosteronism, coarctation of the aorta and increased activity of the beta-adrenergic nervous system.

In patients with renal arterial disease, the most likely cause of hypertension is, of course, the renin-angiotensin system. However, elevations of renin (which is the component most readily measured) are not routinely found. This suggests that other factors are also operating and since blood pressure can be lowered with drugs that suppress the activity of the sympathetic nervous system, this indicates a nervous component in the hypertension as well. In fact, we have recently shown that these patients often have exaggerated increases in blood pressure in response to head-up tilt. Further they tend to have slightly increased cardiac output which may represent an increase in nervous stimulation of the heart. Plasma volume can be decreased and, in our experience, it is inversely related to the plasma renin activity. Additionally, aldosterone production is often increased producing a state of secondary

Dr. Dustan is a member of the research division of the Cleveland Clinic.

aldosteronism. Thus, although we cannot put together all the pieces of information in an integrated fashion, evidence is accumulating that the hypertension accompanying renal arterial disease is an expression of a variety of abnormalities, only one of which is a disturbance of the renin-angiotension system.

In renal parenchymal disease, there is not so much information available concerning the possible pressor factors. However, there have been studies in patients with chronic renal failure which show expansion of the extracellular fluid volumes and correction of hypertension when these excesses are corrected by dialysis. Further, there is a suggestion that with expanded plasma volume the nervous control of the circulation is lessened—possibly because it isn't so necessary when the blood volume is high. Plasma renin activity has not been consistently found to be elevated although increased activity of the renin-angiotensin system seems likely in patients whose hypertension remits following bilateral nephrectomy done in preparation for transplantation. Thus, in this type of hypertension, there are indications that, in one way or another, three pressor factors participate—renal pressor, neurogenic, and fluid volume.

Pheochromocytoma seems a much more straightforward problem than that presented by the other two types of hypertension. Currently, we know that there is increased epinephrine and norepinephrine production, and this seems reason enough for the hypertension. Plasma volume can also be reduced, and this is important because it may explain the hypotensive crises that often occur in these patients following surgical removal of the tumor.

In primary aldosteronism, there is an increased production of aldosterone which can cause increases in body sodium, extracellular fluid volume and plasma volume. Along with these increases, decreased activity of the sympathetic nervous system has been reported. Plasma renin activity is low suggesting that this is not a factor in the hypertension.

Increased activity of the beta-adrenergic component of the sympathetic nervous system can be associated with hypertension. These patients have palpitations and exaggerated tachycardia in response to a variety of normal stimuli, such as exercise. They have increased cardiac output but a normal or near normal peripheral resistance. Their hypertension can be controlled with beta-blocking drugs such as propranolol.

Coarctation of the aorta is also recognized as an occasional cause of hypertension. If patients are not in cardiac failure, apparently hemodynamic functions are normal, at least in the upper parts of the body above the coarctation. However, until flow beyond the coarctation can be measured reliably, hemodynamic characteristics of this type of hypertension cannot be determined. Other pressor mechanisms have not been studied in such patients.

Although most treatments of hypertension are empiric rather than based on specific pressor mechanisms, information is becoming increasingly available in various types of hypertension which bids well to describe a number of integrated circulatory disturbances, of which hypertension is one manifestation. These descriptions will provide rational, rather than empiric, treatment.

Iowa Association of Medical Assistants

Is Your Office Alive?

(Continued from page 343)

Living plants may be used in any way and anywhere to add color and interest to their surroundings. For greater interest, group plants of different leaf texture and color and place them in colorful containers. When using potted plants, never set a porous pot directly upon a highly polished surface. Place it in a glazed jardiniere or a saucer especially designed for this purpose. Commercial metal stands and planters are ideal. You may also use different types of plants massed in planters before picture windows to add beauty from both inside and outside, thus serving a dual purpose. From time to time add a potted plant in full bloom for a touch of color. The facilities in your particular office must be your guide but indoor foliage will respond to even a little TLC (tender, loving care).

Plants, like people, vary somewhat in their affinity for Old Sol. The grape ivy, for an example, enjoys sunshine while the English variety prefers to shun it. They also vary on the amounts of water needed. Most require water only when the soil is dry to the touch. Remember—don't freeze them, cook them, suffocate them, starve them, drown them or dehydrate them. Your florist can help with special problems and when re-potting pick a container only a size or two larger. One too large is worse than one too small for it causes an excess of energy to be diverted into root development and it sours the soil.

The miniature plants now being sent to our offices periodically by a pharmaceutical company are a ready made challenge! Are yours growing?

—JEANNE D. GREEN


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See Brief Summary on next page for information on side effects and contraindications.

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The unique new Vibramycin (doxycycline) V-Pak is especially convenient for use both in your office practice and in the hospital outpatient department. It contains a typical four-day course of therapy for routine infections with easy-to-understand patient instructions. The dosage is low, just 100 mg. b.i.d. the first day followed by 100 mg. once a day for the next three days. In more severe infections, 100 mg. q.12 h. is recommended. If renal impairment exists, lower than usual doses are indicated.

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VIBRAMYCIN® (doxycycline)
BRIEF SUMMARY

Contraindicated: In individuals who have shown hypersensitivity to doxycycline.

Warnings: The usual dosage and frequency of administration of Vibramycin (doxycycline) differs from those of other tetracyclines. Exceeding the recommended dosage may result in an increased incidence of side effects.

If renal impairment exists, even usual doses may lead to excessive accumulation of the drug and possible hepatic toxicity. For such patients, lower than usual doses are indicated and, if treatment is prolonged, Vibramycin serum level determinations may be advisable.

Vibramycin, like other tetracyclines, may form a stable calcium complex in any bone-forming tissue, although *in vitro* Vibramycin binds calcium less strongly than other tetracyclines. The use of Vibramycin during tooth development (last trimester of pregnancy, neonatal period, and early childhood) may cause discoloration of the teeth (yellow-gray-brownish). This effect may occur mostly during long-term use, but also may occur with short-treatment courses.

Increased intracranial pressure with bulging fontanelles has been observed in infants receiving tetracyclines. This effect has disappeared rapidly on cessation of therapy with no sequelae.

In certain hypersensitive individuals treated with Vibramycin, exposure to direct sunlight may precipitate a photodynamic reaction. In individuals with a history of photoallergic reactions to tetracyclines, exposure to direct sunlight should be avoided and treatment should be discontinued at first evidence of skin discomfort.

Precautions: As with any antibiotic, overgrowth of nonsusceptible organisms may occasionally occur. Constant observation of the patient is essential. If such superinfections are encountered, Vibramycin should be discontinued and replaced by appropriate therapy.

When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be utilized. In all cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months.

Adverse Reactions: Nausea, vomiting, diarrhea, vaginitis, as well as reactions of an allergic nature such as dermatitis, urticaria, and anaphylaxis may occur but are rare. Glossitis, stomatitis, proctitis, onycholysis and discoloration of the nails may rarely occur during tetracycline therapy as with other antibiotics. If severe adverse reactions, individual idiosyncrasy, or allergy occur, discontinue medication.

As with other tetracyclines, elevation of SGOT or SGPT values, or elevated BUN have been reported, the significance of which is not known at this time. Anemia, neutropenia, and eosinophilia have been reported, as with other tetracyclines.

Animal Pharmacology: As with other tetracyclines, at doses greater than those recommended for human usage, Vibramycin produces discoloration of animal thyroid glands. Careful monitoring of animals and humans has disclosed no abnormalities of thyroid function studies. Also, as with other tetracyclines, at relatively high oral doses, evidence of hepatotoxicity has been noted in dogs and signs of gastrointestinal intolerance have been seen in both dogs and monkeys.

Dosage: The usual dose of Vibramycin is 200 mg. on the first day of treatment (administered 100 mg. every 12 hours) followed by a maintenance dose of 100 mg./day. The maintenance dose may be administered as a single dose, or as 50 mg. every 12 hours. In the management of more severe infections (particularly chronic infections of the urinary tract), 100 mg. every 12 hours is recommended. The recommended dosage schedule for children weighing 100 pounds or less is 2 mg./lb. of body weight divided into two doses on the first day of treatment, followed by 1 mg./lb. of body weight given as a single daily dose or divided into two doses, on subsequent days. For more severe infections up to 2 mg./lb. of body weight may be used. For children over 100 lbs. the usual adult dose should be used.

Acute gonococcal anterior urethritis in males —a single dose of 300 mg. or 100 mg. b.i.d. for 2-4 days.

Acute gonococcal infections in the adult female should be treated with doses of 100 mg. b.i.d. until cure is effected.

Therapy should be continued beyond the time that symptoms and fever have subsided. When used in streptococcal infections, therapy should be continued for 10 days to prevent the development of rheumatic fever or glomerulonephritis.

If gastric irritation occurs, it is recommended that Vibramycin be given with food or milk. Studies indicate that the absorption of Vibramycin is not markedly influenced by simultaneous ingestion of food or milk.

Simultaneous administration of aluminum hydroxide gel given with tetracycline antibiotics including Vibramycin has been shown to decrease absorption.

Supply: Vibramycin Hyclate (doxycycline hyclate) is available as capsules containing doxycycline hyclate equivalent to 50 mg. of doxycycline, bottles of 50, unit-dose pack of 100 (10 x 10's), and X pack of 50 (5 x 10's); capsules containing doxycycline hyclate equivalent to 100 mg. of doxycycline, bottles of 50, unit-dose pack of 100 (10 x 10's), and V pack of 25 (5 x 5's).

Vibramycin Monohydrate (doxycycline monohydrate) is available as a dry powder for oral suspension containing when reconstituted doxycycline monohydrate equivalent to 25 mg. of doxycycline per 5 cc. (each teaspoonful), with a pleasant-tasting raspberry flavor, 2 oz. bottles.

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
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Vibramycin® (doxycycline)

a semi-synthetic tetracycline

THE DOCTOR'S BUSINESS



Associate Wanted? Examine Your Recruiting Procedures

LARRY E. LEAVERTON
Des Moines

Many Iowa physicians, groups and localities are searching for doctors to fill openings. Glance at the "List Your Wants" pages of this JOURNAL or the classified section of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION and you will see only a portion of the opportunities available to the physician finishing his internship or residency, being released from military service, or to the physician who may be wishing to change from his present location.

The solo practitioner who is considering an associate should first define his needs and his goals. Are there any alternatives? Is he already practicing as efficiently as possible and working at capacity? Does he have well trained personnel? Is he delegating all possible detail? If coverage for time off and vacations is the problem, has a reciprocal arrangement with one or two colleagues been considered? From the standpoint of personality, is he suited to work with an associate?

For the group adding another doctor, advance planning is necessary. The type and specialty of the doctor should be well defined in order for him to fit in with the group. Specific financial arrangements and progression into the group should be planned.

When you have decided you really want to add an associate, every possibility for seeking out applicants should be aggressively explored. The Iowa Medical Society, The American Medical Association, or your specialty association should know of your needs in order that ads can be placed in their journals. Medical schools and hospitals should be approached for lists of interns and residents. Professional placement bureaus, your colleagues, as well as contacts at medical conventions are sometimes valuable. The more persons who know of your needs, the more contacts you will have. Local families may have relatives who are medical officers in service.

Mr. Leaverton has been associated with Professional Management Midwest since 1949. He is a partner in the firm, and is director of its Research and Development Department.

The best prospects are among interns, residents and medical officers in service. They are very selective. They begin checking possible locations well in advance of their availability. Financial arrangements are still a motivating factor, but they are also looking at the community, the schools, cultural and recreational outlets in the area, hospital facilities, the availability of good medical consultants, and the climate, both in terms of weather and economics.

In discussions with applicants, the advantages of medical practice in Iowa should be stressed. One has only to look at the crowded and congested conditions in many parts of the country, with their related problems, to see the benefits enjoyed by many Iowa physicians. In a few minutes of relaxed driving you can get from home to office. In an increasing number of instances medical buildings and complexes are across the street or in the vicinity of the hospitals. National surveys indicate a favorable economic climate for medical practice in Iowa. A trip to a medical meeting or a vacation trip to any part of the country represents only a few hours' travel.

When a prospective associate is located he should be contacted at once. He should be sent a letter describing the opportunity offered. This should be followed up by telephone. These doctors are swamped with offers from all over the country and the personal interest may help him make a decision. If you wait for a reply by mail you may not get it. If he gives an expression of interest, the offer of an expense paid trip to your town or city is suggested. The doctor's wife is frequently an important factor in selecting a practice site so she should be invited also.

Financial arrangements will vary according to individual circumstances; these include the volume of the practice and local factors of supply and demand.

Some doctors have been looking for years for the "right" man. Some have compromised and are sorry, and others are successful in attracting applicants. Competition in recent years has been very keen. If you have been unsuccessful, examine your recruiting procedures.

THE JOURNAL *Book Shelf*



Book Reviews

TEXTBOOK OF NUCLEAR MEDICINE TECHNOLOGY, by *Raul J. Early,* B.S., *Muhammad Abdel Razzak,* M.B.B.Ch., D.M., M.D., and *D. Bruce Sodee,* M.D., F.A.C.P. (St. Louis, C. V. Mosby Company, 1969. $15.50).

This text is specifically designed to be used in the training of nuclear medicine technologists. It is divided into two parts. Part I is concerned with the physics and biology of radiation and methods of detecting and recording radiation. Part II deals with clinical nuclear medicine and is a systems approach with some basic physiology and pathology of the systems being considered. Practical applications and specific details of the most frequently used clinical tests are presented.

Because of the growth of clinical nuclear medicine and its increased application in medical problems the need for trained technologists in this field is expanding. This text will be an aid in the training of these technicians. It can also be used by physicians as a ready reference for the everyday problems of nuclear medicine.—*James T. McMillan,* M.D.

EFFECTIVE MEDICAL ASSISTING; WORKBOOK FOR EFFECTIVE MEDICAL ASSISTING; TEACHER'S MANUAL FOR EFFECTIVE MEDICAL ASSISTING, by *Donovan Ward,* M.D., and *Shirley Pratt Schwarzrock.* (Dubuque, Iowa, Wm. C. Brown Company, 1969. $18.95).

For the aspiring medical assistant, as well as the "girl-Friday" working toward certification, these materials provide an excellent instructional program. Administrative, clerical and clinical material is provided to help the medical assistant learn how to participate effectively as an integral member of the health care team.

Specific discussion is included on receptionist duties, secretarial work, business procedures, medical routines and basic laboratory test work, along with an elementary explanation of radiography.

The 602-page textbook has numerous illustrations with complete summaries and study questions for quick review at the end of each chapter.

The Section on Elementary Medical Knowledge contains a brief history of medicine; medical terminology with a listing of word elements to help develop a basic medical vocabulary; a chapter on first aid, emergency care, bandaging and systems of the body, to name only a few. The appendix contains seven pages of acceptable initials and abbreviations plus a glossary of 20 pages of commonly used terms.

The aim of the text is to alert the neophyte medical assistant to the fundamentals of her job. Technical details which require special training have been omitted. Emphasis is given to the standard of professional conduct necessary to uphold the high principles of medical ethics. *What you see here, what you hear here, what you do here, stays here when you leave here.* This is the strict code wherein the patient's trust and confidence in the physician is inviolate.

Programmed instruction is very effectively utilized in the text, and the 204-page workbook is an aid in self-teaching and testing. The teacher's manual contains teaching suggestions with recommended study times for each section of the textbook. Study groups, as well as individuals, would benefit from this well prepared set of books.—*Jeanne D. Green,* IAMA Past President.

MANIC DEPRESSIVE ILLNESS, by *George Winokur,* A.B., M.D., *Paula J. Clayton,* B.S., M.D., and *Theodore Reich,* B.Sc., M.D., C.M. (St. Louis, C. V. Mosby Company, 1969. $27.50).

In their preface the authors state that "this book is written from the vantage point of a classic position in Psychiatry." Non-psychiatrist physicians may be surprised to discover that this "classic position" is rooted in the empiricism of traditional medicine; seeking to discover specific etiologic agents and specific treatment methods by a rigorous scrutiny of all relevant data and by a precise definition of the syndrome under investigation. Further, this requires that any study of any disease shall take into account all prior investigations regardless of their field of origin.

This approach applied to the study of manic-depressive illness should satisfy most critical readers in that it provides a wealth of organized data derived from genetics, biochemistry, sociology and clinical psychiatry. The material is well organized and condensed so that the reader may easily refer to particular contents of special interest to himself. The authors do not attempt to construct any global theory of explanation for manic-depressive illness, but their data can go a long way in guiding investigators to maintain a disciplined scientific attitude in advance of theory construction.—*Sidney L. Sands,* M.D.

Books Received

PERSONNEL ADMINISTRATION AND LABOR RELATIONS IN HEALTH CARE FACILITIES, by *James O. Hepner,* B.A., M.H.A., Ph.D., *John M. Boyer,* B.A., M.A., and *Carl L. Westerhaus,* B.S., M.S. (St. Louis, C. V. Mosby Company, 1969, $15.00).

TOBACCO AND YOUR HEALTH: THE SMOKING CONTROVERSY, by *Harold S. Diehl,* M.D. (New York, McGraw-Hill Book Company, 1969, $2.95).

PROCEEDINGS OF CENTENNIAL SYMPOSIUM, MANHATTAN EYE, EAR AND THROAT HOSPITAL, VOLUME ONE, OPHTHALMOLOGY, ed. by *Arnold I. Turtz*, M.D. (St. Louis, C. V. Mosby Company, 1969, $27.50).

CRISIS FLEETING, Original Reports on Military Medicine in India and Burma in Second World War, ed. by *James H. Stone* (Superintendent of Documents, Government Printing Office, Washington, D. C., $3.75).

CARDIOVASCULAR SURGERY, VOLUME I, ed. by *Thomas H. Burford*, M.D., and *Thomas B. Ferguson*, M.D. (St. Louis, C. V. Mosby Company, 1969, $18.00).

HANDBOOK OF PSYCHIATRY, ed by *Philip Solomon*, M.D., and *Vernon D. Patch*, M.D. (Canada, Lange Medical Publications, 1969, $7.00).

PROGRESS IN NEUROLOGY & PSYCHIATRY, VOLUME XXIV, ed. by *E. A. Spiegel*, M.D. (New York, Grune & Stratton, 1969, $24.75).

MODERN TREATMENT, Vol. 6, No. 6, TREATMENT OF EPILEPSY AND OTHER PAROXYSMAL DISORDERS, ed. by *J. Gordon Millichap*, M.D., TREATMENT OF HYPERLIPIDEMIA, ed. by *Donald Berkowitz*, M.D. (New York, Harper & Row, 1969, $16.00 per year).

ARTHRITIS AND PHYSICAL MEDICINE, Volume 11 of Physical Medicine Library, edited by *Sidney Light*, M.D., and assisted by *Herman L. Kamenetz*, M.D. (Baltimore, Waverly Press Incorporated, 1969, $14.00).

CARDIAC ARREST AND RESUSCITATION, Third Edition, by *Hugh E. Stephenson, Jr.*, A.B., B.S., M.D., F.A.C.S. (St. Louis, C. V. Mosby Company, 1969, $29.50).

MODERN TREATMENT, Vol. 6, No. 5, TREATMENT OF ACUTE RENAL FAILURE, ed. by *John P. Merrill*, M.D., TREATMENT OF INFECTIOUS FORMS OF ARTHRITIS, ed. by *Frank R. Schmid*, M.D., and *Richard H. Parker*, M.D. (New York, Harper & Row, 1969, $16.00 per year).

May Postgraduate Courses

Veterans Administration Hospital
Des Moines

MONDAY, MAY 11

8:00 a.m. "Special Problems in Surgery of the Aged," Sidney E. Ziffren, M.D., Professor and Acting Head, Department of Surgery, University Hospitals, Iowa City.

FRIDAY, MAY 15

1:15 p.m. "Hepatoma," and "Non-ulcerative and Noncancerous Lesions of the Gastric Antrum," J. C. Thoroughman, M.D., Opelika, Alabama, formerly Chief of Surgery, VA Hospital, Atlanta, Georgia; Clinical Professor of Surgery, Medical College of Georgia, and Professor of Surgery at Emory University.

WEDNESDAY, MAY 20

1:15 p.m. "Pathological Anatomy of the Inguinal and Femoral Regions," C. B. McVay, M.D., Yankton Clinic, Yankton, South Dakota.

FRIDAY, MAY 22

1:15 p.m. "Consideration of Surgery of the Biliary Tract," John L. Madden, M.D., Director of Surgery, St. Clare's Hospital, New York City.

AMA Annual Meeting In Chicago June 21-25

The 119th Annual Convention of the American Medical Association will occur in Chicago from June 21 to 25. The bulk of the Scientific Program (which appears in the May 4 issue of JAMA) will be at the International Amphitheatre.

Approximately 450 scientific and industrial exhibits will be on display. All 23 sections of the Scientific Assembly will be represented. Four general scientific meetings will be addressed to Coma and the Diagnosis of Death, Conception Control and Abortion, The Role of Allied Health Professions in the Delivery of Health Care, and Family Life and the Physician.

Over 10,000 physicians in general practice and all the specialities are expected to attend.

Chicago Meeting May 18 On Medicine and Religion

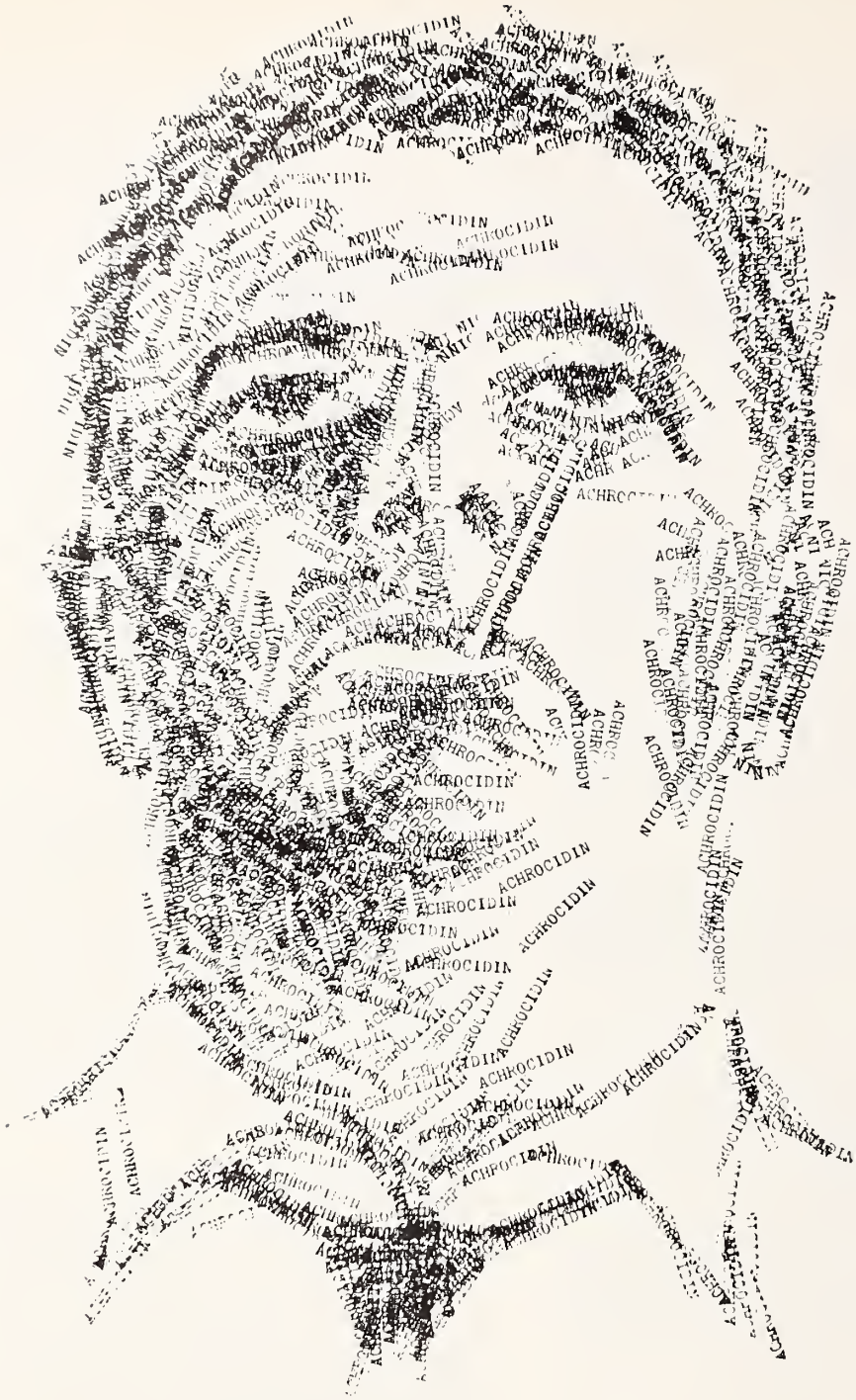
A special program on medicine and religion will be presented in Chicago on May 18 in conjunction with the Annual Meeting of the Illinois State Medical Society. Physicians and clergymen from Iowa have been invited to attend the special program to be held at 9:00 a.m. at the Sherman House Hotel.

The half-day program will be on the theme *Crisis of the Dying Patient* and will feature as speakers, Elisabeth K. Ross, M.D., Chief Consultation and Liaison Section, LaRabida Children's Hospital, Chicago; Reverend Carl A. Nighswonger, Chaplain, University of Chicago Hospitals, and Reverend Dr. Paul B. McCleave, Director, Department of Medicine and Religion, American Medical Association. The research of Dr. Ross and Chaplain Nighswonger in this area has been reported in LIFE magazine.

New Surgical Division Established

The Department of Surgery at the University of Iowa College of Medicine has established a new division devoted exclusively to peripheral vascular problems. The chairman is Doctor Montague S. Lawrence.

Iowa physicians are invited to send problem cases of this nature to this division either by contacting Doctor Lawrence by letter in care of the Department of Surgery or by calling him at 316-356-2271.



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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

535-9

STATE DEPARTMENT OF HEALTH

ARNOLD M. REEVE, M.D., M.P.H., COMMISSIONER

Urge Cooperation In National X-ray Exposure Study

The Public Health Service is conducting a national study to obtain information on population exposure to diagnostic and therapeutic X-radiation. The study began on April 13, and is being made jointly by the Bureau of Radiological Health and the National Center for Health Statistics. The study was planned with the advice of a group of radiologists and physicists representing the American College of Radiology.

The study follows two earlier national X-ray surveys by Public Health Service agencies. The first was conducted in 1961 to estimate the volume of medical and dental X-ray visits in the United States. A more comprehensive study was made in 1964 to extend the X-ray visit data to include exposure and dose estimates for the U. S. population in that year.

The 1970 study will use the same collection and analysis methods employed in the 1964 survey so that results of the investigations will be directly comparable. This will afford the opportunity to evaluate the effectiveness of programs to improve X-ray practice and reduce unnecessary exposure. The 1970 study also will aid in establishing guidelines for future programs.

The new study will be conducted in three phases:

- A household interview survey to obtain the X-ray visit experience of a representative sample of the U. S. population. This phase will run from April 13 through October 12 and will cover about 20,000 households and 65,000 persons.
- A follow-up questionnaire to obtain examination data from X-ray facilities identified in the household survey. From May through December, approximately 5,000 facilities will be asked to supply these details. Authorization to request the information will be obtained in advance from household respondents.
- An X-ray equipment survey to provide physical measurements in a selected sub-sample of X-ray facilities. This phase will be conducted by specially trained State and Federal radiological health personnel.

Based on data obtained during the household and facility surveys, a descriptive analysis of the population's X-ray experience in 1970 will be prepared. The information, which will be categorized by pertinent demographic and facility characteristics, will include estimates of numbers and rates for: (1) persons X-rayed, (2) X-ray visits, and (3) X-ray examinations and exposures.

Estimates of gonadal and genetically significant dose will be derived from the study findings by applying mathematical models developed at the Johns Hopkins and Emory Universities in collaboration with the 1964 study. It is also planned to extend these data into dose estimates for other selected body organs through the use of related research results.

Since this study is based on a small representative sample, the cooperation of each practitioner contacted in the follow-up phase is essential to meet the study objectives. All information pertaining to individual patients, practitioners and facilities will be treated confidentially. Only statistical summaries will be made available for publication.

Additional information about plans for the survey may be obtained from the Bureau of Radiological Health, 1901 Chapman Avenue, Rockville, Maryland 20852.

Gonorrhea in Iowa

Gonorrhea showed an increased incidence in 1969. During 1969, 4,409 cases were reported to the Department of Health. This is a 10 per cent increase over the preceding year and a 33 per cent rise in two years. The table portrays the contin-

TABLE OF GONORRHEA INCIDENCE, IOWA

Age Group	Year 1955	1960	1965	1969
0- 9	0	4	4	5
10-14	4	18	16	54
15-19	118	304	554	1,324
20-24	145	497	950	1,733
25-29	122	268	457	715
30-34	42	139	220	296
35-39	25	55	120	144
40-44	21	31	85	70
45+	22	23	95	68
Total	499	1,339	2,501	4,409

ued upward trend of incidence of the disease over the past 19 years. Since 1955, the reported incidence of this disease has increased 884 per cent, almost nine times! The number of reported cases has more than doubled on the average every five years!

The table shows most of the cases occur in persons between 15 and 29 years of age. The five year age group with the greatest number of cases is persons between 20 and 25 years old. The high incidence of this venereal disease parallels the sexual activity of these age groups.

A remarkable finding from the study of gonorrhea over these two decades of years is the change in incidence among youths in the first half of the teen years. For the first 15 years there was little change in incidence in persons between 10 and 15 years. In 1969 an increase in incidence in this age group was first noted. From less than 20 cases per year the incidence has now increased to 54 cases.

This finding may, and very likely does, reflect a greater sexual activity in this five-year age group. The preponderance of cases continues to occur in the older persons, but the table points out that youth is being increasingly infected.

It is important that all persons, and especially the young, know the symptoms of the disease: a pusy discharge, pain on urination, soiling of clothing. Females often have minimal or no early symptoms. The first symptoms may appear long after the disease was contracted. Then they may have pain in the side or lower abdomen, caused by acutely inflamed fallopian tubes.

Recommended Immunization Schedule for Iowa

The following is a compromise of the recommendations of the American Academy of Pediatrics and the Public Health Service Advisory Committee on Immunization Practices.

A. CHILDREN, 0-18 YEARS OF AGE

Immunizing Biological	Best Age to Begin	Number of Doses	Boosters
DIPHTHERIA AND TETANUS TOXOIDS, PERTUSSIS VACCINE (DTP)	2 months	3 injections 1 month apart.	1 year later and again at 3 years of age. Subsequent boosters of Diphtheria-Tetanus (Adult type) at ages 6 and 12.
TETANUS AND DIPHTHERIA TOXOIDS, COMBINED (For Adult Use) (TD)	6 years and over if not previously immunized	2 injections 4 to 6 weeks apart.	1 year later, then at 10 year intervals or if wounded.
MEASLES VACCINE LIVE VIRUS*	12 months	ATTENUATED (may or may not be accompanied by modifying gamma globulin)—1 injection OR FURTHER ATTENUATED (No gamma globulin) —1 injection.	Not presently considered necessary.
MUMPS VIRUS VACCINE, LIVE*	12 months	1 injection	Not presently considered necessary.
POLIOVIRUS VACCINE, LIVE ORAL (SABIN)*	2 months	TRIVALENT: Primary immunization of infants less than 1 year—3 oral doses 8 weeks apart OR MONOVALENT: 3 oral doses 6 to 8 weeks apart	1 dose of Trivalent at about 1 year later and again before entrance to school. No further boosters presently considered necessary.
	1 year and above	Preschool, school and adult—2 oral doses of TRIVALENT 8 weeks apart. OR 3 oral doses of MONOVALENT 6 to 8 weeks apart.	
RUBELLA VACCINE LIVE VIRUS*	12 months	1 injection	Unknown at present.
SMALLPOX VACCINE*	Between 1st and 2nd birthday	1 vaccination—vaccinate with extra caution during hot summer months.	Revaccination at entry into school and at 10 year intervals. Medical personnel at 3 year intervals.

* Present recommendations suggest that all live virus immunizations be separated, one from the other, by 4 week intervals.

B. ADULTS

SMALLPOX—Vaccination every 10 years or upon exposure. To meet U. S. international travel requirement, vaccination or revaccination must have been received within three years of the date of re-entry into the United States. No vaccination is required for entry into the U. S. from Mexico if no other country has been visited within 14 days of entry. Every vaccination should be observed by the physician at least once to see that it is successful. Initial vaccination should be read on the seventh day and revaccination on about the fifth day. Unsuccessful vaccinations should be repeated, but not until at least two weeks after the first try, lest a superimposition occur. Medical and hospital personnel, morticians and others likely to be exposed to smallpox introduced into the U. S. should be revaccinated at three year intervals.

TETANUS—The original series is two 0.5 cc injections, intramuscularly, at four to eight week intervals, followed by a third dose about a year after the second. To maintain protection, boosters should be given at 10-year intervals. A booster injection of 0.5 cc should be given promptly after any injury or before surgical work on old wounds. If wounding occurs within one year of booster, another booster probably is not indicated except under very exceptional circumstances.. Begin new 10-year booster interval from date of any booster.

DIPHTHERIA—Use only toxoids labeled for adult use. Tetanus-Diphtheria Toxoids, combined (for adult use) is the agent of choice, administered according to above schedule for tetanus.

TYPHOID—Routine typhoid immunization is NOT recommended in the U. S. Intimate and continuous contact with a typhoid carrier or travel to areas where typhoid is endemic are indications for typhoid vaccination. There are no data to support typhoid vaccine use before attendance at summer camps or in flood situations. The primary series is two 0.5 cc doses given subcutaneously at intervals of four or more weeks. In areas of high typhoid incidence, a booster dose of 0.5 cc may be given every three years. Use of vaccine containing Para-typhoid A and B antigens is NOT recommended.

INFLUENZA—For persons who have not had a vaccine containing recent strain within the preceding two years, two 1 cc injections subcutaneously at a four to eight week interval between doses. Those who have had such vaccine within two years need only one 1 cc injection. Immunizations should be obtained in late September or early October to protect during the usual influenza season. Primary target group is debilitated, aged or infirm persons, particularly those living in institutions.

POLIOMYELITIS—Adults need this immunization only when traveling abroad or should an epidemic occur. Follow the schedule for children.

C. SCOPE OF THESE RECOMMENDATIONS

The immunizations are recommended for Iowans in Iowa. With few exceptions, such as the need for Rocky Mountain Spotted Fever vaccine for persons whose work may take them to certain areas, these recommendations are adequate for the entire United States. Other immunizations are needed for travel outside of the United States. Information on these may be obtained by requesting our sheet "Immunizations for Overseas Travel."

Morbidity Report for Month of March, 1970

Diseases	March 1970	1970 to Date	1969 to Date	Most March Cases Reported From These Counties
Amebiasis	1*	1*	0	Dallas
Brucellosis	2	5	1	Sac
Chickenpox	733	2,617	1,878	Black Hawk, Johnson, Linn, Polk
German measles	349	971	844	Cass, Linn
Gonorrhea	445	1,195	847	Scattered
Impetigo	60	180	121	Black Hawk, Lee
Infectious hepatitis	23	84	103	Carroll, Woodbury
Infectious mononucleosis	69	214	194	Johnson
Influenza A2	3	15		Jackson—2; Johnson—1
Malaria, imported P. vivax	1*	5	3	Greene
Measles	27	48	136	Polk
Meningitis, bacterial	1	1	0	Scott
cryptococcic	1	1	0	Fayette
H. influenzae	2	2	5	Marshall, Muscatine
meningococcal	2	3	9	Marshall, Ringgold
Mumps	473	1,296	2,501	Black Hawk, Wapello
Pneumonia	102	264	155	Pottawattamie, Scott
Rabies in animals	5	21	26	Hardin, Iowa, Mitchell, Poweshiek, Worth
Rheumatic fever	6	13	18	Clayton
Salmonellosis				
S. litchfield	1	1	0	Cherokee
S. orion	1	1	0	Story
S. typhimurium	2	6	10	Dubuque, Polk
Group B	1	3	8	Polk
Group C	1	1	0	Page
Shigellosis				
S. sonnei	3	26	4	Linn—1; Polk—2
Streptococcal infections	815	2,427	1,587	Jefferson, Johnson
Syphilis	66	142	180	Scattered
Tuberculosis, active	19	35	36	Scattered
Whooping cough	2	5	4	Polk

* Delayed

Woman's Auxiliary News



Meet President Prewitt

Mrs. L. H. Prewitt (Marion) is a native Iowan and a real booster of the Hawkeye State. She was graduated Phi Beta Kappa from the University of Iowa and earned the M.A. degree at Columbia University. At present she is teaching English part-time at Ottumwa Heights College.

Marion has been active in many civic groups: P.T.A., United Fund, Iowa Council Teachers of English, P.E.O., Shakespeare Club, Irving Study Club, and has been a Precinct Committeewoman. She belongs to both the St. Joseph Hospital Auxiliary and Ottumwa Hospital Auxiliary, and has given many hours of service to the latter on the building and furnishing committees.

Dr. and Mrs. Prewitt have a son, Leland, Jr., who is a third-year medical student at Iowa; and a daughter, Mariann, who works in her father's office. The family attends the First United Methodist Church.

Marion's hobbies are knitting, reading, and bridge.

A Welcome and a Challenge

Welcome to a new year, to a new decade in the Woman's Auxiliary to the Iowa Medical Society. As always, when a new year begins, we look back with pride to the accomplishments of the preceding year, cherishing the friendships, the fellowship of it and other years; then we look ahead and try to chart a course for the new dimensions that emerge in a rapidly changing present and future. Paraphrasing Tennyson, looking backward we are conscious of what was not accomplished and our forward glance chastens us with what may not be done.

We are a service organization, an organization that serves our husbands, bless them, in their work, and the profession of medicine which they serve. "Serving people and nations everywhere starts with serving somebody somewhere." I am using this quotation from Health Careers to suggest a springboard for the coming year. I ask you to add another dimension to Serve—Speak. Auxilians have many ways in which to serve that will speak for them, but the time has come for us to speak to others and to each other about what we have done and what we hope to do.

As long as we can remember, next to the religious the medical profession has enjoyed the highest pinnacle of respect; the doctor was a hero. But "this is the age, not of the hero, but of the operator," and when the federal government assumes the role of big brother, the medical profession must find ways to bridge the gap between the new pattern and holding the standards that made the doctor a hero.

This is an area where we as wives, mothers, sisters and daughters can make rounds. At the fall conference Mrs. R. C. L. Robertson, national president-elect, told us about the little boy in the first grade whose teacher asked him to draw a picture showing his father's occupation. He drew circles. Patiently she explained the assignment again. Again his sheet of paper held only circles. The teacher tried again, "How do these circles ex-

plain what your father does?" This was the answer; "When my daddy leaves home in the morning he tells my mother that he's going to the hospital to make rounds."

To make rounds in our communities is our job. We must analyze the needs where we live, anticipate problems and work out solutions with the advice and help of our parent medical societies. This is where it all begins—on the local level. Communication is a transaction, involving reception as well as transmission so we must broadcast on the wavelength of the people we want to reach, all of them, because "no man is an island unto himself"; all of us are involved in the health care system; we as Auxiliary members have the responsibility, and the privilege, of making it work better.

How, then, do we serve and speak? National and state officers can suggest only general guidelines with specific examples of what has worked in some situations. You must supply the missing link—make the adaptation or create the means to the end you seek in individual situations. All of us are active people involved in church, P.T.A., civic affairs, clubs; service, social and cultural.

Use these channels to speak for health, for medicine. Use the package programs on alcohol, drug abuse, smoking and eight other subjects prepared by national headquarters. They are listed on page 27 of the March issue of M.D.'S WIFE. The M.D.'S WIFE magazine is a splendid source of information and know how.

On the national level, Health Careers and AMA-ERF are major priorities in the forecast for 1970-71. Work out with your medical society and public health nurses a program to kindle interest and enthusiasm on junior and senior high school levels in Health Careers. Let's compete for these youngsters the way athletic departments recruit players.

You have seen the wares offered by Jane Perkins, AMA-ERF chairman. Promote as many as you can at every Auxiliary meeting. The loan fund is asking for active support, too; Uncle Sam won't be able to do it all.

Iowa is in the throes of a great state wide project: Rub out Rubella. If you are not involved, volunteer your services where they can be used and provide financial assistance if needed. Immunization clinics, the handicapped, those who need hot, nourishing meals, homemaker service are all candidates for community service attention.

While caring for others, we are reminded to be concerned for the health of physicians. We have been indoctrinated not to advertise, but we can explain, inform, educate, and we can show by specific example that we mean what we say. We can be a formidable force under the direction and guidance of our medical societies.

Legislation is more important than ever before. Are you familiar with the One Dozen Days Public Affairs program? A member promises to give a dozen days (five hours constitute a day and may be done piecemeal) of service to the political party or to the civic activities of her choice. Battles are fought, and won or lost, on the political front. Know your congressmen, both local and national. Invite them to your meetings, speak to them about your opinions; ask for their support and offer yours. Join IMPAC and AMPAC—we need all the professional skill we can muster in the field of public relations. But don't forget personal concern and participation in your own backyard.

How is your county prepared for disaster? Where do you rate in accident prevention and safety? Do you make johnny coats, knit bandages, send magazines, books to International Health Organizations? There is no finer way to serve away from home.

What can you do for mental health in urban and rural situations? Do you know that the food a child eats in the first 18 months of his life will affect his I.Q., will retard or advance him mentally? Here is an area for great cooperation with the children and youth committee. There is a great challenge for us to educate children and youth about alcohol, drug abuse and tobacco. If we give our youth facts, and offer co-operation instead of criticism, Serve and Speak, perhaps we can make a vital contribution. To avoid duplication see how you can mesh your efforts on the local level. Team teaching is "the thing." It's more fun that way, too.

Communication is the life line of our organization. Share your ideas, your projects, your comments, your travels with us. The chairman of the NEWS will twice or thrice bless you. Speak out! But don't limit your communication to the written word. Another goal is to see 34 presidents at Board Meetings. *Show* us what's happening where you are. These are only a few of the ways to Serve and Speak.

On the state level there are some objectives. Each state has been asked to prepare a history of its activities for the last five years. If you have interesting information about your Auxiliary past, 1965-70, please send it to the Historian or one of the officers who will pass it along.

I have mentioned that individual participation is vital to the heart and soul of any project, so it may seem paradoxical to talk about organized membership, but only members can speak for *Organized* Medicine. There is strength in union—how well we should know! It has been a dream, never realized, to have a member, county organization or at-large, from every county in the state. We have 1,270 out of a possible 2,000 potential members. The member-at-large has a unique opportunity to Serve and Speak. She has no bosses except her husband member of IMS. All officers, committee chairmen and councilors will gladly furnish her with any information or help she needs to be a one woman dynamo.

This is the year we hope to revise the By-laws to make them flexible for our needs. Don't hesitate to make suggestions; let us know what you want us to do, and what kind of an organization you need in your community. We will operate an open forum in the NEWS for your opinions.

You have 12 officers, 11 councilors, 17 committee chairmen and 34 county presidents to look to for guidance and material. Work them as they have never been worked before. Unless we can be a vital, energizing force we cannot justify the faith and support of our parent organization or our existence to each other.

Ever mindful of the contribution of our predecessors, may we begin a new year with faith and hope, Serving Somebody Somewhere and Speaking out in the cause of organized medicine.

—MRS. L. H. PREWITT

Around the Hawkeye State

Boone County

The newly-elected officers for the Auxiliary to the Boone County Medical Society are as follows: President, Mrs. John Anderson, Boone; Vice President, Mrs. Enfred Linder, Ogden; Secretary, Mrs. Donald Cross, Boone, and Treasurer, Mrs. John Murphy, Boone.

On March 17, the Auxiliary met at the Imperial Inn Restaurant for a luncheon meeting. Following the business meeting, the group toured the Boone Junior-Senior High School. A film strip was shown explaining the school's new modular system. Information was provided on the proposed plans for a new school building.

Buchanan County

The Buchanan County Medical Auxiliary has purchased a flag pole for the new children's unit at the Independence Mental Health Institute. A plaque at the base of the flag pole indicates the donor. The funds for this project were derived from the Auxiliary's 1969 annual dinner-dance.

Cerro Gordo County

Greetings from Cerro Gordo County. We feel our Auxiliary is ending a successful year.

This past fall we sponsored a health career day and a homebound handcraft sale. The health career day was attended by 105 students from 12 high schools in the NIACC area. The day's activities included hospital tours, films and small discussion groups on special interest fields.

With the local Easter Seal Society, we co-sponsored our first homebound handcraft sale. Total receipts were $776.76 for the three-day sale held in the mall of a shopping center.

In January, we sponsored a program for the monthly senior citizens meeting. Four speakers discussed how to get to a hospital, what to take, changes in the Medicare program, extended care facilities and nursing homes and services and supplies available after discharge from the hospital.

Our March meeting was an afternoon meeting and a dinner with our husbands in late April closed our present year.

Marion County

Marion County doctors wore red carnations as they went about their duties March 30. The flowers were presented to the physicians by the Marion County Medical Auxiliary in recognition of National Doctors' Day.

The members of the Marion County Medical Society also were guests of the Auxiliary at a dinner held at Pine Knolls Country Club April 3.

Pottawattamie County

The Pottawattamie County Medical Auxiliary held its annual Benefit Bridge Party at Gib's Western Kitchen April 13. Theme of the event was "Le Detnier Cti."

The noon luncheon was followed by a fashion show and an afternoon of bridge. Mrs. Russell Forrest was general chairman, assisted by Mrs. Fethi Gonlubol, Mrs. Walter Hathaway, Mrs. Jose Martinez and Mrs. M. P. Margules.

Models showing the latest fashions in women's clothing and accessories were: Mesdames Gonlubol, Hathaway, Karin Inankur, Cemal Adlai, Charles Edwards, Sr., and Joseph Kruml.

Proceeds from this Benefit will be donated to the Iowa School for the Deaf.

Be thankful your job is a little harder than you wish—a razor is not sharpened on velvet.

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501

President-Elect—Mrs. P. H. Tenney, 203 Second Avenue, SW, Independence 50644

Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312

Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228

Editor of THE NEWS—Mrs. J. L. Kehoe, 111 McClellan Blvd., Davenport 52803



Personals



Dr. Bernard G. Pineda, of Burlington, spoke at the March meeting of the Corse School PTA in that community. His topic was "The Emotionally Disturbed Child."

Dr. Richard F. Wilker, of Creston, described his work as an army doctor in Vietnam at the 12th annual spring outlook meeting of the Union County Extension Service. Dr. Wilker illustrated his talk with slides taken in Vietnam. Dr. Wilker returned to his practice in Creston several months ago after two years of service as an army doctor. He spent a year in Vietnam.

Dr. Kirk H. Strong, of Fairfield, participated in a recent joint meeting of members of four Mennonite Churches. The meeting was held in Pulaski. Dr. Strong discussed the use and abuse of drugs.

Dr. F. G. Dannenbring, a Fort Dodge pediatrician, was guest speaker at the March meeting of the Welcome Wagon Club in Fort Dodge. His topic was "The Measles Vaccine."

Dr. Walter J. Kopsa, of Tipton, has been named head of the Hoover Health Council, a regional health agency recently endorsed by the Johnson County Board of Health. The regional body includes Benton, Cedar, Delaware, Iowa, Johnson, Jones, Linn and Washington counties.

Dr. Walter A. Anneberg, of Carroll, will receive the U. of I. Distinguished Service Award at an all-alumni luncheon in the Memorial Union at Iowa City on May 16. A Carroll physician for 46 years, Dr. Anneberg has been an outstanding leader and contributor to civic, church and professional institutions. He is a past president of the Carroll Rotary Club and its senior member. Dr. Anneberg was president of the Carroll Chamber of Commerce in 1935 and is a past president of the Carroll County Medical Society. Recently, he served as chairman of the fund-raising drive for a new $6 million St. Anthony Regional Hospital which is now under construction. A life member of the Alumni Association, Dr. Anneberg has returned to the campus frequently to assist with numerous projects.

Dr. M. L. Northup, of Humboldt, has been appointed Lay Director of St. Mary's Parish there. A native of Des Moines, Dr. Northup received his M.D. degree at the U. of I. College of Medicine in 1954. He served his internship at St. Joseph's Hospital in Phoenix, Arizona, and moved to Humboldt in 1955. The appointment of Dr. Northup as Lay Director coincides with the reorganization of the executive and finance boards of the parish. **Dr. Beryl Michaelson**, of Dakota City, has been appointed to the finance board of the parish.

Dr. John N. Kenefick, of Algona, has retired from medical practice for reasons of ill health. Dr. Kenefick has practiced medicine for 39 years. He was recently released from St. Ann Hospital in Algona, where he had been under care for a heart condition.

Drs. Joseph E. O'Donnell and **George York**, of Clinton, have agreed to share the duties of health officer in Clinton. **Dr. A. L. Jensen** formerly held this post.

At a recent meeting of the Cass County Medical Society, **Dr. Dwight Stone**, of Atlantic, was elected president and **Dr. Keith Swanson**, also of Atlantic, was elected secretary-treasurer. Dr. Swanson conducted a seminar on diseases of the colon at the meeting.

Dr. C. R. Burroughs, of Knoxville, has announced he and his family will leave Knoxville on August 1 to make their home in Houston, Texas. Dr. Burroughs will begin a one-year course in cardiology at the Baylor School of Medicine and Texas Medical Center in Houston. He has been associated with the Mater Clinic and Collins Memorial Hospital for 18 years. Tentative plans call for his return to the Knoxville area upon completion of his medical studies.

Dr. Daniel M. Kelly, of Emmetsburg, discussed drugs, their use and abuse, at the March meeting of the Friday Club in Emmetsburg.

Dr. Madelene Donnelly Healy has been named the new Executive Director for the 21-member North Iowa Health Council. From 1950 until her recent retirement, Dr. Healy served as Director of Maternal and Child Health with the Iowa State Department of Health.

Dr. Harold Moessner, of Amana, was chairman of the Cancer Crusade conducted in Iowa County in April.

Drs. John B. Dixon and **Luke Chang**, both Mason City physicians, recently spoke to the senior citizens at The Manor home in Mason City. They discussed aging diseases of the eye and degenerative arthritis.

Dr. Glen Nielsen, of Des Moines, has been appointed associate medical director of The Bankers Life. Dr. Nielsen has been assistant medical director since joining the company in 1963. He is the medical director of the Convalescent Home for Children and on the staff of Iowa Methodist, Mercy, Iowa Lutheran and Broadlawns hospitals.

Dr. Richard A. Myers, of Independence, has been named to the executive committee of the newly-formed Buchanan County Crime Commission.

Dr. David Thaler, president of the medical staff of St. Luke's Hospital in Cedar Rapids, announced recently the emergency room of St. Luke's will now be staffed by full-time physicians. Physicians in charge of the emergency services are **Drs. Henderson E. Galbreath** and **Thomas E. Porter.** Dr. Galbreath received his M.D. degree from the University of Nebraska and Dr. Porter from the University of Illinois. Both interned in Cedar Rapids.

Dr. Raymond G. Bunge, professor of urology at the U. of I., received the highest award of the American Fertility Society at a recent meeting of the Society in Washington, D. C. The Society cited Dr. Bunge's "pioneering research leading to a better understanding of human reproduction" and selected him to receive the $1,000 Ayerst Award. Award winners are chosen from among the world's top scientists.

Dr. William Bennett, a Marion physician, participated in a panel discussion on drug abuse at the March meeting of St. Joseph's Home School Association in Cedar Rapdis.

Dr. Ward B. Litton, associate professor of otolaryngology and maxillofacial surgery at the U. of I., has received a $9,036 grant from the Deafness Research Foundation. The grant will be used to seek a better understanding of Meniere's disease.

Dr. Dennis G. Emanuel, of Ottumwa, was one of the speakers at the Ottumwa Deanery semi-annual Pre-Cana Conference for young couples preparing for marriage. The March meeting was at Walsh High School in Ottumwa.

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

A most worthwhile mechanism for creating a memorial to a relative, associate, colleague or friend exists in the Scanlon Medical Foundation/Iowa Medical Society. The Foundation utilizes memorial gifts to carry forward its loan program which has helped more than 300 young Iowans finance their medical educations. The Foundation will be glad to send an appropriate card in the name of the donor to the family of the person honored. The tax-deductible memorial gifts should be directed to the Scanlon Medical Foundation/ Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

Dr. James H. Coddington, of Humboldt, participated recently in a local panel discussion on "How Drug Addiction Affects Our Families." The discussion was sponsored by the Humboldt County Republican Women's Club.

Dr. Donald L. Warkentin, an associate professor in the Department of Internal Medicine at the U. of I., recently conducted an Iowa Regional Medical Program for physicians in the Boone area. The all-day meeting was held at the Boone County Hospital. Dr. Warkentin's topic was "Practical Aspects of Diagnosing and Treating Coronary Patients."

Upon his retirement as Morningside College physician, **Dr. Charles Berkstresser**, of Sioux City, was honored with his wife at a reception on March 22 at the college. Dr. Berkstresser has served Morningside College and the community for 49 years. He has been college physician since 1936. He is still practicing medicine and has no plans to retire from his profession. A 1921 graduate of the U. of I. College of Medicine, Dr. Berkstresser organized the health services at Morningside.

Dr. John Martin, of Clarinda, was one of the speakers at a workshop on "Hospital and Home Care of Stroke Patients" held in early March at the Mental Health Institute in Clarinda.

Dr. L. F. Parker, of Iowa Falls, has left for St. Lucia, British West Indies, where he will donate his services for a month at a hospital operated by St. Jude's nursing order. The 150-bed hospital, formerly an Air Force base hospital, is only partially used at the present time. Mrs. Parker accompanied him on the trip. In 1967, Dr. and Mrs. Parker spent several weeks in Guatemala, where Dr. Parker donated his services at a hospital and in the surrounding villages. Mrs. Parker assisted with records and other work.

Dr. William C. Robb, of Fort Dodge, is one of 10 volunteers who will serve on the board of directors of the newly-formed Kidney Foundation of Iowa. Physicians from the U. of I. Veterans Administration Transplantation Center who have agreed to serve on the Foundation's medical advisory board are **Drs. William W. Bonney, Richard M. Freeman,** and **Richard L. Lawton,** all of Iowa City. The Iowa group has now applied for a charter and affiliation with the National Kidney Foundation.

Dr. J. G. McCarroll, of Fort Dodge, was installed as president of the Bethesda General Hospital

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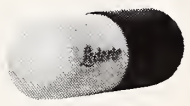
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medical staff at its 37th annual meeting held in Fort Dodge recently. Dr. McCarroll succeeds retiring president, **Dr. F. D. Lawson**, also of Fort Dodge. Other officers elected were **Dr. Frank S. Larsen**, Fort Dodge, president-elect; **Dr. M. L. Northup**, Humboldt, vice-president; and **R. H. Brandt**, Fort Dodge, secretary. **Dr. Earl F. Rose**, an associate professor in the Department of Pathology at the U. of I. College of Medicine, addressed the medical staff on "Murder and the Medical Examiner." Two physicians who died during the year, **Dr. C. J. Smith**, of Gilmore City, and **Dr. H. F. Kiesling**, of Lehigh, were honored with a silent tribute.

Dr. William H. Olin, professor of otolaryngology and maxillofacial surgery at the U. of I. College of Medicine, presented the presidential address at the annual meeting of the American Cleft Palate Association. In his talk, Dr. Olin suggested the group's area of interest be extended to include all head and face defects in addition to cleft palate.

Dr. L. C. Faber, Dubuque, was guest speaker at the March meeting of the Marquette faculty. His topic was "Drugs." Faculties of the area schools, both parochial and public were in attendance.

Dr. Patrick J. Cusack has joined the Valley Clinic in Fort Madison and is serving as radiologist at the Sacred Heart Hospital there. Dr. Cusack has been in practice in Newton for the past eight years.

Dr. Donald J. Ahrenholz, of Cedar Falls, was the guest speaker at a meeting of the Waterloo Council, Christian Business and Professional Women of America. Dr. Ahrenholz spoke on drugs and showed a film on the use of narcotics.

Dr. F. B. O'Leary, of Sibley, and **Dr. T. E. Shea**, of Storm Lake, were co-chairmen of a stroke symposium held in Sioux City recently as part of the Northwestern Stroke Program of the Iowa Heart Association. The program was offered cooperatively with the Iowa Regional Medical Program. **Dr. E. G. Nafziger**, of Sioux City, assisted Dr. O'Leary and Dr. Shea in arranging the symposium.

"Your Heart" was the subject of a talk given by **Dr. J. L. Walker**, of Newton, at a recent meeting of the Newton Woman's Club. Dr. Walker used slides to illustrate the causes, factors and risks of heart disease.

Dr. Robert L. Kollmorgen has joined **Dr. Louis D. Rodgers** in the practice of general surgery in Des Moines. Dr. Kollmorgen earned his M.D. de-

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gree at the University of Nebraska. He served his internship at Kansas City General Hospital and his residency at Iowa Methodist Hospital in Des Moines.

Dr. Dean M. Lierle, an Iowa City otolaryngologist, presented the Benjamin Shuster Memorial Award at the sixth annual scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery, Inc., held April 24-26 at the Hollywood Beach Hotel in Hollywood, Florida. The award is presented for outstanding research in head and neck plastic surgery by a resident physician.

Dr. Andre Lascari, assistant professor of pediatrics at the U. of I., recently participated in the 14th Annual Pediatric Conference held in Des Moines at Raymond Blank Memorial Hospital.

Dr. Frederick C. Brush, of Mason City, told of his experiences aboard the S. S. Hope at the March meeting of the Rockwell Harmony Club.

Several Iowa radiologists were among those receiving the Fellowship degree of the American College of Radiology at the annual meeting of the college held in Dallas, Texas, April 3. They are as follows: **Steven H. Cornell**, M.D., of Iowa City, **Walter G. Dennert**, M.D., of Boone, **John H. Lohnes**, M.D., of Cedar Rapids, **William S. Thomas**, M.D., of Sioux City, **Hal R. Hirleman**, M.D., of Cedar Rapids, and **John R. Utne**, M.D., of Mason City.

Dr. Hermann M. Burian, professor of ophthalmology at the U. of I. College of Medicine, has been elected president of the International Strabological Association, an integral part of the International Council of Ophthalmology. Dr. Burian will serve a four-year term.

Dr. George L. Baker, associate professor at the U. of I. College of Medicine, recently presented two talks at a postgraduate program on "Care of the High Risk Infant," held at the University of Missouri Medical Center. Dr. Baker also discussed the unique transport system he developed at the U. of I. in which a specially equipped mobile nursery is on 24-hous call to bring infants with serious medical problems to the University Health Center.

Drs. Lloyd J. Filer and **Samuel J. Fomon,** both professors in the Department of Pediatrics at the U. of I. College of Medicine, recently participated in the Governor's Conference on Food, Nutrition and Health held at the C. Y. Stephens Auditorium, Iowa State University, Ames.

Dr. Marcus Emmons, of Clinton, was the guest speaker at a TOPS (Take Off Pounds Safely) rally held in DeWitt recently.

Dr. Howard B. Latourette, a professor in the Department of Radiology at the U. of I., spoke at the West Liberty United Methodist Church in early March. "Women and Cancer" was the title of the program sponsored by the three Federated Women's Clubs of West Liberty. Dr. Latourette's presentation included the American Cancer Society film "Time and Two Women."

Dr. C. P. Phillips, of Muscatine, has retired after 46 years of general practice during which time he delivered 3,411 babies. A 1922 graduate of the U. of I. College of Medicine, Dr. Phillips first entered private practice with his uncles at Clear Lake, following an internship at two Chicago hospitals. He later practiced in Alexander for two and one-half years and came to Muscatine on January 1, 1927. Dr. Phillips has donated much of his office equipment to the Planned Parenthood Association of Muscatine.

Dr. Wilson C. Wolfe, an Ottumwa otolaryngologist, resumed his private practice on Monday,

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March 2, at the new Professional Plaza in Ottumwa. Dr. Wolfe has practiced in Ottumwa since 1939, and previously was located in the Hofmann Building.

Dr. David W. Wetrich, a member of the Wapello County Medical Society now serving a residency at University Hospitals in Iowa City, spoke on abortion at a recent meeting of the county society and its auxiliary. Dr. Wetrich terminated his practice with **Drs. D. G. Emanuel** and **E. W. Ebinger** in March of 1966 to enter the Army. He served in Vietnam. Following his discharge, Dr. Wetrich accepted a residency at University Hospitals for further training in obstetrics and gynecology. He received his M.D. degree from the U. of I. and interned at Los Angeles County General Hospital.

Drs. Arthur L. Sciortino and **Duane D. Warden**, both of Council Bluffs, have been named division leaders in the 1970 Cancer Crusade in Pottawattamie County.

Dr. Thomas E. Kiernan has assumed duties as radiologist at Skiff Memorial Hospital in Newton. Dr. Kiernan replaces **Dr. P. J. Cusack,** who recently resigned. A 1959 graduate of the U. of I. College of Medicine, Dr. Kiernan practiced general medicine for six years in Sioux Center. He started his radiology residency at the U. of I. in 1967 and completed it in February. While in general practice, Dr. Kiernan was active in county and state medical society activities and served a two-year term as director of the Iowa Blue Shield Program.

Dr. R. E. Weland, of Cedar Rapids, was the guest speaker at a recent kickoff dinner meeting of the Tama County Cancer Crusade held in Garwin.

Deaths

Dr. John E. Traister, 92, longtime Eddyville physician and surgeon, died on Monday, March 2, at the Shahan Nursing Home in Eddyville. A 1906 graduate of the Keokuk Medical College, Dr. Traister practiced in Eddyville for almost 50 years. In 1957, he was voted an emeritus membership in the Association of American Physicians and Surgeons. He was a past president of the Wapello County Medical Society.

Dr. L. M. Downing, 91, a Cedar Rapids pediatrician for 36 years, died at his home on Sunday, March 22, following a brief illness. Dr. Browning graduated from the University of Iowa College of Medicine in 1903. He practiced in Wellman from 1903 to 1916, then went to the Harvard Medical School to specialize in pediatrics. Dr. Downing established his pediatrics practice in Cedar Rapids in 1917, and was active until his retirement in 1953. He was a life member and past president of the Linn County Medical Society and also a life member of the Iowa Medical Society and the Pediatrics Society.

Dr. John D. Caulfield, 69, a New Hampton physician since 1939, died March 17 at St. Joseph Community Hospital in New Hampton. Dr. Caulfield received his medical education in Chicago at DePaul Academy, Loyola University and Illinois Eye and Ear Infirmary. He was a member of the American Board of Ophthalmology, Pan American Association of Ophthalmologists and was a past president of the Chickasaw County Medical Society.

Dr. Eugene F. Van Epps, 58, a past president of the Iowa Medical Society, died on March 11 in Albuquerque, New Mexico. A former head of the Radiology Department at the U. of I., Dr. Van Epps left Iowa City in 1968 to go to Duke University and last fall accepted a position at the University of New Mexico. Dr. Van Epps had also served as secretary and chairman of the IMS Judicial Council.



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Burroughs-Wellcome & Co. 306B

Campbell Soup Company 334A
Casualty Indemnity Exchange 371
Conal Pharmaceuticals, Inc. 370A

Dow Chemical Company 306A

Geigy Pharmaceuticals 306D, 307

Hoechst Pharmaceuticals 338
Hynson, Westcott & Dunning, Inc. 299

Lederle Laboratories 301, 352, 362
Lilly, Eli, & Company 297, 316

Medical Protective Company 363
Merck, Sharp & Dohme 302-304
Merrell, William S., Company 315

National Drug Company 298, 314A, B

Pfizer, Chas., & Company, Inc. 346-348
Poythress, Wm. P., & Company 306C, 334D
Prouty Company 340

Roche Laboratories 372

Searle, G. D., & Company 334B, C
Seven-Up Bottlers of Iowa 365
Silver Shield Plan 364
Stuart Pharmaceuticals 370B

Wyeth Laboratories 341-342

JOURNAL of The IOWA MEDICAL SOCIETY



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IN THIS ISSUE

- Massive Hemothorax Caused by Bleeding From an Intercostal Artery—Paul T. Davidson, M.D.
- A Capsule Review of Mental Retardation—Walter M. Block, M.D.
- A Case Report: Occupational Exposure to the Insecticide Naled—David L. Mick, Ph.D., Thomas D. Gartin, M.D., and Keith R. Long, Ph.D.
- The Medical Approach to Male Homosexuality—Richard A. Truax, M.D., William S. Moeller, M.D., and Garfield Tourney, M.D.



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Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

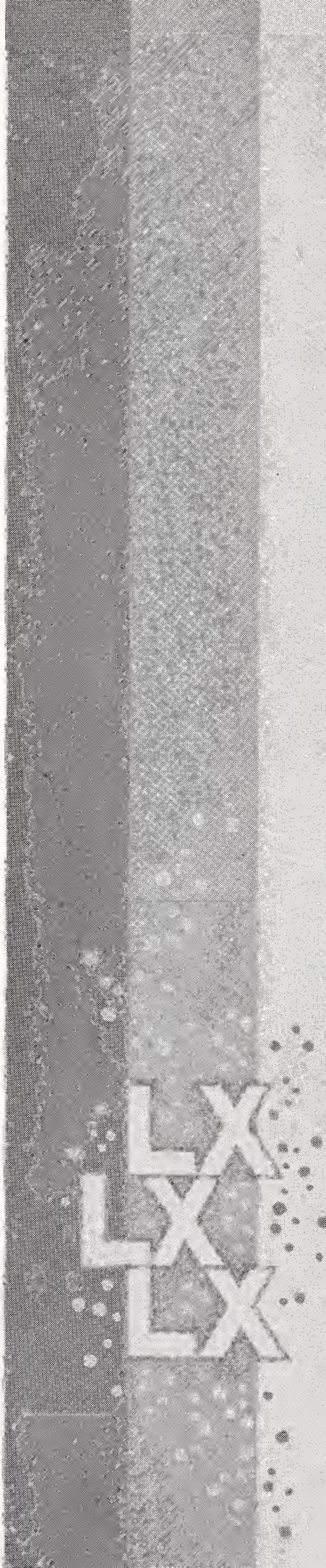
No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)



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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

The JOURNAL of THE IOWA MEDICAL SOCIETY

Vol. LX JUNE, 1970 No. 6

CONTENTS

SCIENTIFIC ARTICLES

Massive Hemothorax Caused by Bleeding From an Intercostal Artery
Paul T. Davidson, M.D. 389

A Capsule Review of Mental Retardation
Walter M. Block, M.D. 393

A Case Report: Occupational Exposure to the Insecticide Naled
David L. Mick, Ph.D., Thomas D. Gartin, M.D., and Keith R. Long, Ph.D. 395

The Medical Approach to Male Homosexuality
Richard A. Truax, M.D., William S. Moeller, M.D., and Garfield Tourney, M.D. 397

EDITORIALS

The Danger of Extremism 405

Surgical Management of Diverticulitis 406

What Is Air Pollution? 408

Perforation of Infant Rectum 409

Problems of Obesity 410

SPECIAL DEPARTMENTS

Coming Meetings 381

The Month in Washington 382

In the Public Interest facing page 398

President's Page 404

Information from the Iowa Heart Association
"Tetralogy of Fallot"
James R. Malm, M.D. 411

Iowa Association of Medical Assistants 413

State Department of Health 414

The Doctor's Business 418

Woman's Auxiliary News 420

Personals 424

Deaths 429

MISCELLANEOUS

AMA & JAYCEES Launch Project 381

1970 Annual Meeting Scenes 386

Unveil Painting of Dr. Scanlon 403

Retains IMS Golf Crown 416

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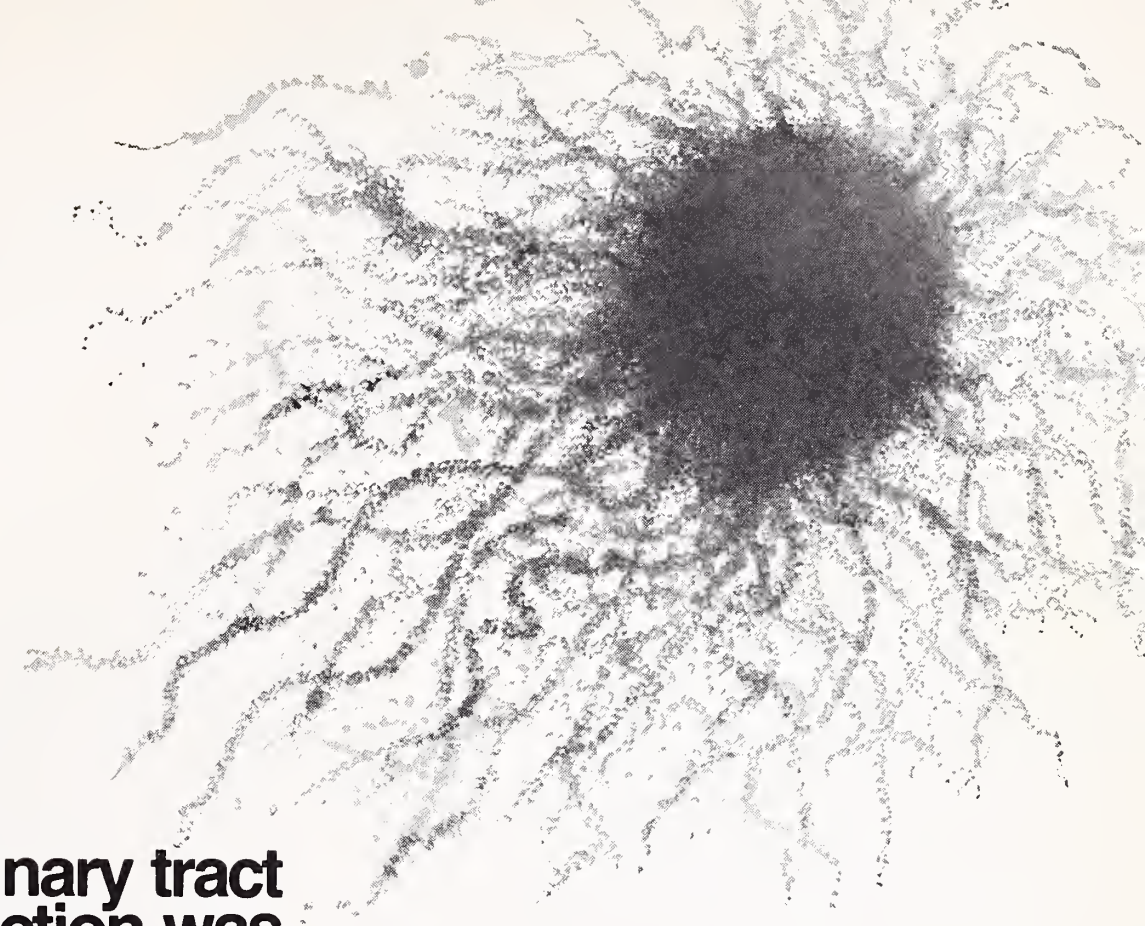
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A urinary tract infection was eliminated last week

ıtestinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

It doesn't let monilia begin where bacteria end. Declostatin® 300

Demethylchlortetracycline HCl 300 mg and
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Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

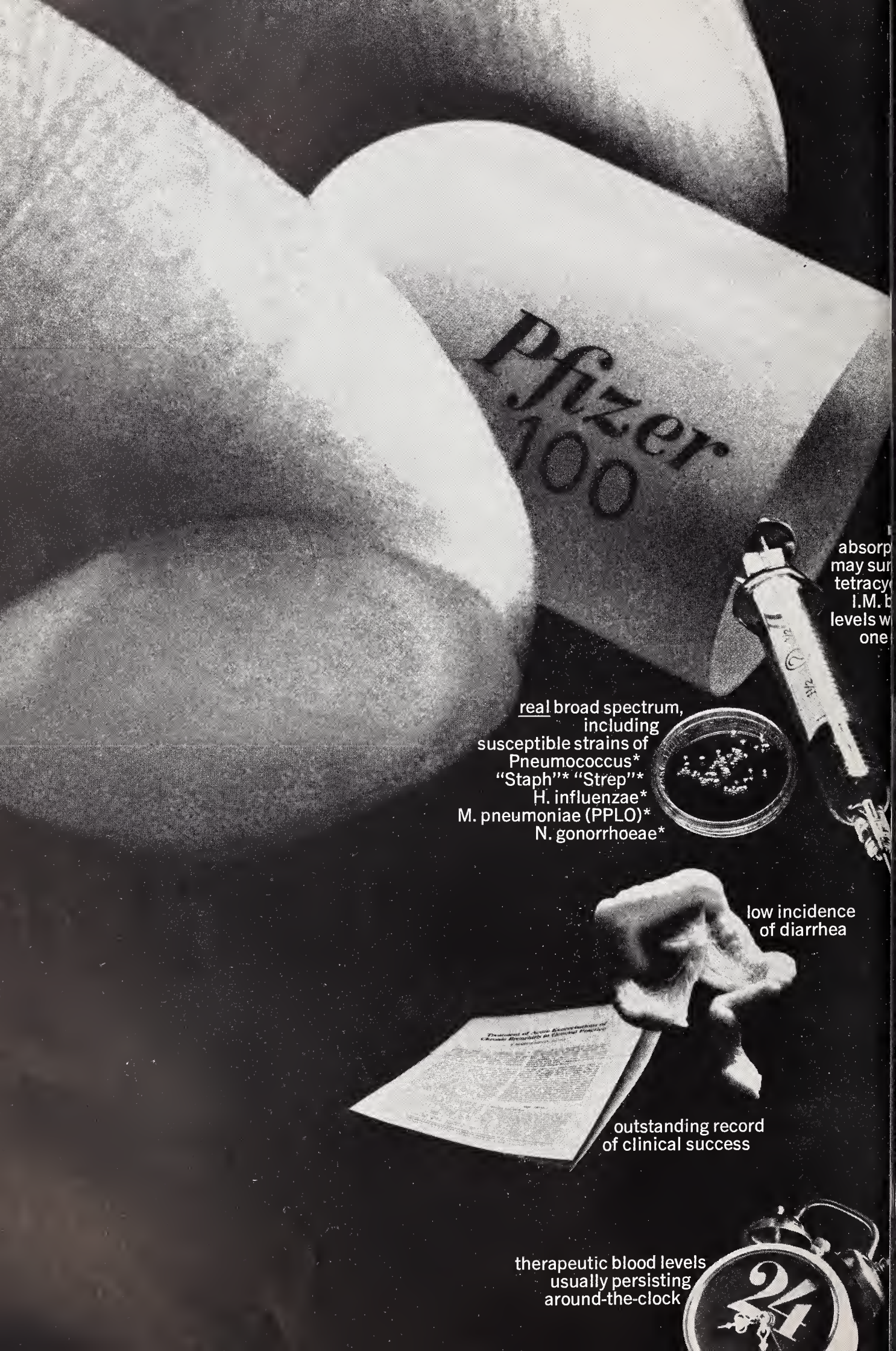
Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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of clinical success
therapeutic blood levels
usually persisting
around-the-clock
24



high tissue levels

unlike other tetracyclines can be given with milk or meals

The effectiveness you need.
The advantages you look for.

Vibramycin® (doxycycline)

a semi-synthetic tetracycline

*Because not all strains of pathogens are susceptible, it is recommended that routine culture and susceptibility studies be performed. When using Vibramycin (doxycycline) in streptococcal infections, therapy should be continued for 10 days to prevent the development of rheumatic fever or glomerulonephritis.

See Brief Summary on next page for information on side effects and contraindications.

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and convenience too.

The unique new Vibramycin (doxycycline) V-Pak is especially convenient for use both in your office practice and in the hospital outpatient department. It contains a typical four-day course of therapy for routine infections with easy-to-understand patient instructions. The dosage is low, just 100 mg. b.i.d. the first day followed by 100 mg. once a day for the next three days. In more severe infections, 100 mg. q.12 h. is recommended. If renal impairment exists, lower than usual doses are indicated.

And for added convenience in the hospital pharmacy, Vibramycin is available in unit-dose packs of 100 (10 x 10's) for both the 100 mg. and the 50 mg. capsules.

VIBRAMYCIN® (doxycycline)
BRIEF SUMMARY

Contraindicated: In individuals who have shown hypersensitivity to doxycycline.

Warnings: The usual dosage and frequency of administration of Vibramycin (doxycycline) differs from those of other tetracyclines. Exceeding the recommended dosage may result in an increased incidence of side effects.

If renal impairment exists, even usual doses may lead to excessive accumulation of the drug and possible hepatic toxicity. For such patients, lower than usual doses are indicated and, if treatment is prolonged, Vibramycin serum level determinations may be advisable.

Vibramycin, like other tetracyclines, may form a stable calcium complex in any bone-forming tissue, although *in vitro* Vibramycin binds calcium less strongly than other tetracyclines. The use of Vibramycin during tooth development (last trimester of pregnancy, neonatal period, and early childhood) may cause discoloration of the teeth (yellow-gray-brownish). This effect may occur mostly during long-term use, but also may occur with short-treatment courses.

Increased intracranial pressure with bulging fontanelles has been observed in infants receiving tetracyclines. This effect has disappeared rapidly on cessation of therapy with no sequelae.

In certain hypersensitive individuals treated with Vibramycin, exposure to direct sunlight may precipitate a photodynamic reaction. In individuals with a history of photoallergic reactions to tetracyclines, exposure to direct sunlight should be avoided and treatment should be discontinued at first evidence of skin discomfort.

Precautions: As with any antibiotic, overgrowth of nonsusceptible organisms may occasionally occur. Constant observation of the patient is essential. If such superinfections are encountered, Vibramycin should be discontinued and replaced by appropriate therapy.

When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be utilized. In all cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months.

Adverse Reactions: Nausea, vomiting, diarrhea, vaginitis, as well as reactions of an allergic nature such as dermatitis, urticaria, and anaphylaxis may occur but are rare. Glossitis, stomatitis, proctitis, onycholysis and discoloration of the nails may rarely occur during tetracycline therapy as with other antibiotics. If severe adverse reactions, individual idiosyncrasy, or allergy occur, discontinue medication.

As with other tetracyclines, elevation of SGOT or SGPT values, or elevated BUN have been reported, the significance of which is not known at this time. Anemia, neutropenia, and eosinophilia have been reported, as with other tetracyclines.

Animal Pharmacology: As with other tetracyclines, at doses greater than those recommended for human usage, Vibramycin produces discoloration of animal thyroid glands. Careful monitoring of animals and humans has disclosed no abnormalities of thyroid function studies. Also, as with other tetracyclines, at relatively high oral doses, evidence of hepatotoxicity has been noted in dogs and signs of gastrointestinal intolerance have been seen in both dogs and monkeys.

Dosage: The usual dose of Vibramycin is 200 mg. on the first day of treatment (administered 100 mg. every 12 hours) followed by a maintenance dose of 100 mg./day. The maintenance dose may be administered as a single dose, or as 50 mg. every 12 hours. In the management of more severe infections (particularly chronic infections of the urinary tract), 100 mg. every 12 hours is recommended. The recommended dosage schedule for children weighing 100 pounds or less is 2 mg./lb. of body weight divided into two doses on the first day of treatment, followed by 1 mg./lb. of body weight given as a single daily dose or divided into tw doses, on subsequent days. For more severe infections up to 2 mg./lb. of body weight ma be used. For children over 100 lbs. the usual adult dose should be used.

Acute gonococcal anterior urethritis in males —a single dose of 300 mg. or 100 mg. b.i.d. for 2-4 days.

Acute gonococcal infections in the adult fem should be treated with doses of 100 mg. b.i.d until cure is effected.

Therapy should be continued beyond the tim that symptoms and fever have subsided. When used in streptococcal infections, thera should be continued for 10 days to prevent the development of rheumatic fever or glomerulonephritis.

If gastric irritation occurs, it is recommended that Vibramycin be given with food or milk. Studies indicate that the absorption of Vibramycin is not markedly influenced by simultaneous ingestion of food or milk.

Simultaneous administration of aluminum hy droxide gel given with tetracycline antibiotics including Vibramycin has been shown to decrease absorption.

Supply: Vibramycin Hyclate (doxycycline hyclate) is available as capsules containing doxycycline hyclate equivalent to 50 mg. of doxycycline, bottles of 50, unit-dose pack of 100 (10 x 10's), and X pack of 50 (5 x 10's); capsules containing doxycycline hyclate equivalent to 100 mg. of doxycycline, bottles of 50, unit-dose pack of 100 (10 x 10's and V pack of 25 (5 x 5's).

Vibramycin Monohydrate (doxycycline mono hydrate) is available as a dry powder for oral suspension containing when reconstituted doxycycline monohydrate equivalent to 25 m of doxycycline per 5 cc. (each teaspoonful), with a pleasant-tasting raspberry flavor, 2 oz. bottles.

More detailed professional information available on request.

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New York, N.Y. 10017

Vibramycin® (doxycycline)

a semi-synthetic tetracycline

COMING MEETINGS

IN STATE

June 8-12 **Internal Medicine, 1970—Old Principles—New Practice sponsored by American College of Physicians,** University of Iowa College of Medicine, Iowa City.

CONTINENTAL U. S.

June 3-5 **Postgraduate Course on Pathology, Pathologic Physiology and Clinical Aspects of Renal Disease sponsored by American College of Physicians,** Georgetown University Hospital, Washington, D. C.

June 8-9 **Conference on Medical Staff Organization and Management sponsored by Catholic Hospital Association,** Convention-Exposition Center, Cincinnati.

June 8-12 **Psychiatry and the Internist sponsored by American College of Physicians, University of Maryland Hospital and Psychiatric Institute,** Baltimore.

June 13-14 **American Diabetes Association,** Stouffer's Riverfront Inn, St. Louis.

June 15-17 **American Neurological Association,** Claridge Hotel, Atlantic City.

June 15-17 **Postgraduate Course on Cardiac Auscultation sponsored by American College of Physicians,** New York University School of Medicine, New York.

June 15-17 **Postgraduate Course on Blood Transfusion Therapy and Related Immunology sponsored by American College of Physicians,** Michigan State University, East Lansing, Michigan.

June 15-19 **Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta, Georgia.

June 15-20 **General Practice Review,** YMCA Conference Center, Estes Park.

June 18-19 **American Rheumatism Association,** Statler-Hilton Hotel, Detroit.

June 20-21 **Society for Vascular Surgery,** Conrad Hilton Hotel, Chicago.

June 21-25 **Annual Convention of American Medical Association,** Chicago.

June 22 **Fireside Grand Rounds presented by American College of Chest Physicians and American Medical Association,** Conrad Hilton Hotel, Chicago.

June 22-23 **First Annual Interdisciplinary Conference on Health Records sponsored by Association for Health Records,** Columbus, Ohio.

June 23-24 **American Medical Society on Alcoholism,** American Hospital Association Building, Chicago.

July 6-9 **Postgraduate Course on Ophthalmology sponsored by University of Colorado School of Medicine,** Estes Park.

July 17-18 **Rocky Mountain Cancer Conference,** Brown Palace Hotel, Denver.

July 19-22 **Postgraduate Course in Pediatrics sponsored by University of Colorado School of Medicine,** Aspen, Colorado.

July 20-23 **Ruidoso Summer Clinic, 13th Annual, sponsored by New Mexico Chapter of American Academy of General Practice,** Chaparral Motel, Ruidoso, New Mexico.

July 27-31 **Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta, Georgia.

July 27-31 **Postgraduate Course on Internal Medicine sponsored by University of Colorado School of Medicine,** Estes Park, Colorado.

July 27-31 **Seminar on Simulation of Biological Systems sponsored by EAI Los Angeles Analysis and Computation Center,** El Segundo, California.

ABROAD

June 21-25 **Canadian Anesthesiologists' Society, Annual Meeting,** Winnipeg, Manitoba.

June 22-25 **6th International Congress, American Thyroid Association,** Vienna.

July 12-18 **International Society of Urology,** 15th Congress, Tokyo.

July 12-18 **4th Quadrennial World Congress of Gastroenterology.** Copenhagen.

August 2-8 **13th International Congress of Hematology,** Munich, Germany.

August 3-7 **11th International Congress on Diseases of Chest sponsored by American College of Chest Physicians,** Lausanne, Switzerland.

August 23-28 **Flying Physicians Association Meeting,** Vancouver, B.C., Canada.

August 28-29 **Scandinavian Neurosurgical Society, Annual Meeting,** Stockholm.

AMA & JAYCEES Launch Project

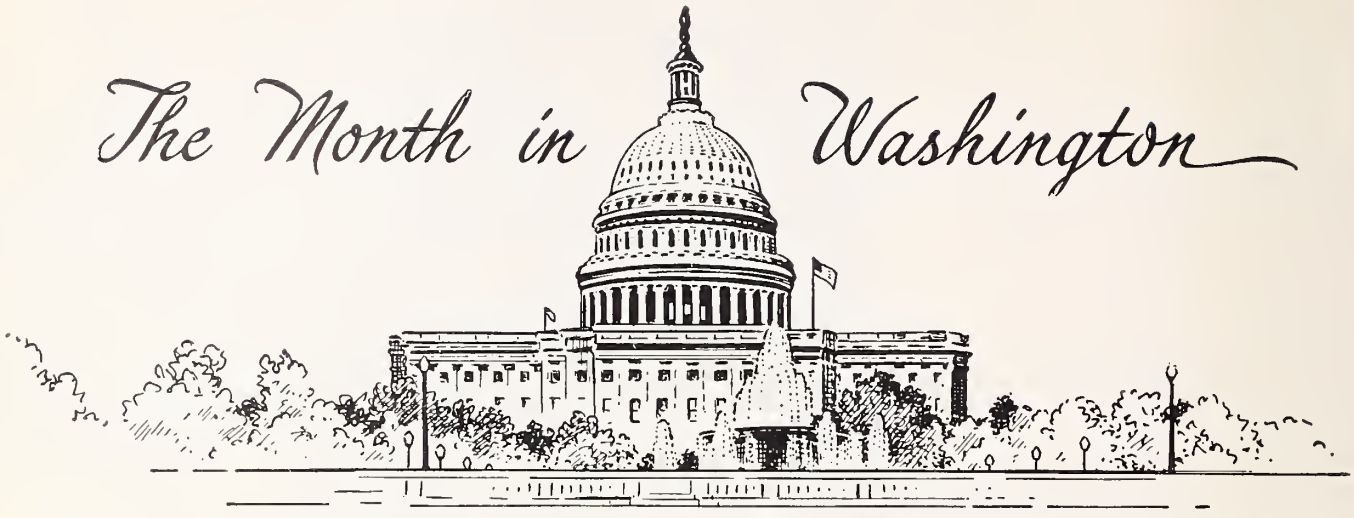
The American Medical Association and the U. S. Junior Chamber of Commerce have launched a joint program to improve the nation's emergency services. Need for the program has evolved from studies which show that approximately 20,000 accident victims died in 1969 because they were lifted when they should have been left alone; or because they were not treated for shock, did not get enough oxygen on the way to the hospital, or ran out of blood on the way to the hospital.

The program anticipates the use of the 325,000 jaycees across the country as catalysts to bring to the attention of the public the need for standardized emergency vehicle equipment, properly trained medical attendants and a better communications system between vehicles and hospitals.

The AMA has distributed over 9,000 program kits to jaycee chapters and medical societies. Kits are still available on request from the AMA.

The packet includes sample publicity materials, a first aid manual, a directory of state and local emergency medical services, guidelines for community councils, etc.

The Month in Washington



Washington—The House Ways and Means Committee has approved legislation (1) to change the Medicare program to permit prepaid closed-panel group practice care and (2) to set ceilings on physicians' fees under Medicare and Medicaid.

The Committee did not consider national health insurance proposals for legislative action this year.

A proposal for inclusion of chiropractic under Medicare was rejected. However, a compromise provision would direct the Health, Education and Welfare Department to conduct a "very limited" study of chiropractic under Medicare, utilizing the experiences under Medicaid. Chiropractic now is a Medicaid service in 15 states (including Iowa), being authorized for federal funds to the extent that it is legal in the state. Representatives of chiropractors have lobbied intensively for the same treatment under Medicare.

The Committee also decided against inclusion of Social Security disabled beneficiaries under Medicare. Instead, the proposal was referred to the Health Insurance Benefits Advisory Council for further study.

The House was expected to approve the Committee's bill, which includes a five per cent increase in cash Social Security benefits, without change. Changes were expected in the Senate.

Provisions of the Committee bill include:

• *Health Maintenance Organization Option:* Individuals eligible for both Part A and Part B Medicare coverage would be able to choose to have their care provided by a health maintenance organization (a prepaid group health or other capitation plan). The government would pay for such coverage on a capitation basis not to exceed 95 per cent of the cost of Medicare benefits provided to beneficiaries in the area not covered under the health maintenance organization.

• *Experiments and Projects in Prospective Reimbursement and Incentives for Economy:* The Secretary of HEW would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under Medicare, Medicaid and Maternal and Child Health. In addition, the Secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy, and with community-wide utilization review mechanisms.

• *Limitation on Recognition of Physician Fee Increases:* Charges determined to be reasonable under the present criteria in Medicare, Medicaid, and Maternal and Child Health law would be limited by providing: (a) that for fiscal year 1971 medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during calendar year 1969; (b) that for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased, on the average, only to the extent justified by increases in the cost of production of medical services, levels of living and the earnings of other professional, managerial and technical personnel; and (c) that for medical supplies, equipment and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such supplies, equipment and services are widely available in a locality.

• *Payments for Services of Teaching Physicians:* Medicare and Medicaid would not pay for the services of teaching physicians unless other patients who have insurance or are able to pay are also charged for such services and the Medicare deductibles and coinsurance amounts are regularly collected. Medicare attached payment would be authorized for services to hospital patients by staff of certain medical schools that now furnish these services without charge to the hospital.

• *Termination of Payments to Providers Who Abuse the Medicare Program:* The Secretary of HEW would be given authority to terminate or suspend payment for services rendered by a supplier of health and medical services found to be guilty of program abuses. Program review teams

(Please turn to page 383)

(Continued from page 382)

would be established to furnish the Secretary professional advice in carrying out this authority.

• *Repeal of Medicaid Provision Requiring Expanded Programs:* The requirement in present law that states have comprehensive Medicaid programs by 1977 would be repealed.

• *Prohibition of Reassignments:* Medicare and Medicaid payments to anyone other than a patient or his physician would be prohibited, unless the physician is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services.

• *Utilization Review in Medicaid:* Require hospitals and skilled nursing homes participating in the Medicaid and Maternal and Child Health programs to have the same utilization review committee with the same functions as in the Medicare program.

• *Role of State Health Agencies in Medicaid:* State health agencies would be required to perform certain functions under the Medicaid and Maternal and Child Health programs relating to the quality of the health care furnished to recipients.

• *Physical Therapy Services Under Medicare:* Under Medicare's supplementary medical insurance program, beneficiaries would be covered for up to $100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's prescription. Hospitals and extended care facilities could continue to provide covered physical therapy services to patients who have exhausted their days of hospital insurance coverage.

• *Chiropractors' Services:* HEW would conduct a study on covering chiropractors' fees (on a very limited basis) under Medicare, utilizing the experimental authority under the Medicaid program. A report on the study, including the experience of other programs paying for chiropractors' services, would be submitted to the Congress within 2 years.

* * *

The American Medical Association has expressed opposition to a proposed oral contraceptive package insert addressed to users.

The Food and Drug Administration first proposed a package insert of about 700 words dealing with possible side-effects and potential dangers of taking birth control pills. When this raised widespread opposition, the FDA drastically revised the original draft, cutting it down to about 100 words. Main objections to the first draft were that it was too long and detailed to be addressed to a patient and that it raised a serious question about the relationship between doctor and patient.

After the FDA invited comments on the revised draft from interested parties, Dr. Ernest B. Howard, executive vice president of the AMA, responded that the AMA opposes any oral contraceptive package insert. He said that, "in the best interests of the patient and the practice of quality medicine," there should be no package insert addressed to users.

". . . The requirement that information on the side-effects of a prescription drug be supplied directly to the patient is a dangerous departure from present practice," he said in a letter to the Health, Education and Welfare Department, of which FDA is a part. "It intrudes upon the patient-physician relationship and compromises individual medical evaluation. The proposed statement would lead to confusion and alarm among many patients and could result in harm to some.

"For these reasons, the American Medical Association is opposed to a package insert directed to patients for any prescription drug.

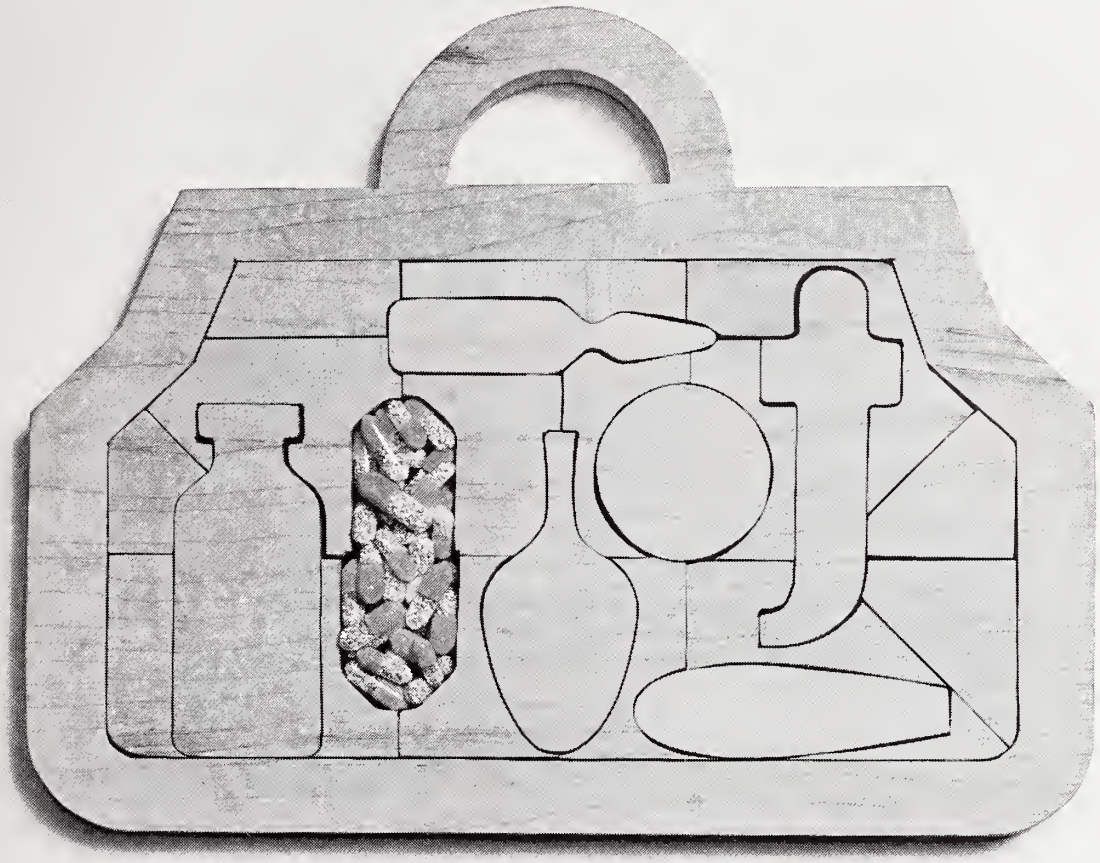
"The oral contraceptive is a prescription drug. It is the responsibility of the physician to inform his patients of the potential hazards of drugs he prescribes. In counseling on family planning, the physician has a further responsibility. He should provide information that will enable the patient to make an intelligent decision regarding the use of oral and other contraceptive methods."

"The proposed statement, in its simplistic approach to a complex situation, would confuse the patient who has already been informed of possible side-effects by her physician and who has received her physician's recommendation as to a desirable method of contraception for her. . . .

"A stated purpose of the insert is to 'reinforce the efforts of the physician to inform the patient in a balanced fashion of the risks.' The physician has a duty to weigh the benefits against the possible risk in prescribing any drug for a patient, and the physician's advice to the patient in connection with the drug prescribed must be individualized for each patient. The balanced fashion theory cannot be a part of good therapeutic practice, which requires an individual judgment for each patient. Standardized information could harm some patients by limiting the value of the specific information given to them by their physicians.

"A package insert is an inappropriate and ineffective means of providing a patient with information regarding any prescription drug. The best way to inform patients effectively is through the physician. The best way to reinforce the physician's efforts to inform the patient is to provide him with unbiased, authoritative and up-to-date information. Our Council on Drugs has used the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION for this purpose. Further, in a forthcoming book titled AMA DRUG EVALUATIONS, we will supply the physician with comprehensive information on oral contraceptives as well as on other drugs. . . ."


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1970 Annual Meeting Scenes

Four busy spring days (April 26-29) are recalled pictorially below and on the adjoining page. These photos were taken during the 1970 Annual Meeting of the Iowa Medical Society.

Upper left, below, W. M. Krigsten, M.D., Sioux City, immediate past president, presents the John F. Sanford Award to Kenneth Barrows, vice-president, The Bankers Life, Des Moines. Recipients of Life Membership Awards are shown in the upper right photo. Left to right are N. E. Weems, M.D., Paullina, G. S. Marquis, M.D., Des Moines, H. F. Peasley, M.D., Des Moines, A. G. Felter, M.D., Van Meter, R T. Paige, M.D., LaPorte City, John Maxwell, M.D., What Cheer, C. M. Franchere, M.D., Mason City, and J. C. Mooney, M.D., Des Moines.

Lower left, Rubin H. Flocks, M.D., Iowa City, right, receives the Ben T. Whitaker Teaching Award from S. P. Leinbach, M.D., Belmond. Lower middle, K. E. Lister, M.D., president, Scanlon Medical Foundation, visits with medical students William Hicks and Mark Messingham, participants in the Foundation loan program. Lower right, E. E. Gamet, M.D., Lamoni, receives the IMS Merit Award from Dr. Lister.

New IMS officers are shown in the upper left photo on the adjoining page. Left to right are H. R. Hirleman, M.D., Cedar Rapids, vice-president, L. J. O'Brien, M.D., Fort Dodge, president-elect; R. L. Wicks, M.D., Boone, trustee. Seated is J. H. Sunderbruch, M.D., Davenport, president. Upper right, left to right, V. L. Schlaser, M.D., Des Moines, IMS secretary, and S. P. Leinbach, M.D., visit with W. L. Boyd, University of Iowa president and an Annual Meeting speaker.

Past presidents of the Society are shown upper middle left. Seated, left to right, are R. N. Larimer, M.D., Sioux City, J. W. Billingsley, M.D., Newton, and O. D. Wolfe, M.D., Marshalltown. Standing are C. V. Edwards, Sr., M.D., Council Bluffs, C. W. Seibert, M.D., Waterloo, S. P. Leinbach, M.D., Belmond, O. N. Glesne, M.D., Fort Dodge, and R. F. Birge, M.D., Des Moines. In the upper middle right photo, J. F. Bishop, M.D., Davenport (right), IMS Judicial Council chairman, confers with Hormoz Rassekh, M.D., Council Bluffs, a new Council member.

Lower middle left, K. E. Lister, M.D., Ottumwa, chairman of the IMS Board of Trustees (center), presents check to R. C. Hardin, M.D., vice-president for health affairs, University of Iowa. Looking on is J. W. Eckstein, M.D., new dean of the College of Medicine. Lower middle right, members of the Iowa Association of Medical Assistants, pause during their coffee serving.

Lower left, Society gavel passes from W. M. Krigsten, M.D., (left) to incoming president J. H. Sunderbruch, M.D., Davenport. Middle lower photos show three reference committee chairmen giving reports. Middle left, H. E. Wichern, M.D., Des Moines; upper right, C. R. Aschoff, M.D., Cedar Rapids; lower right, D. F. Rodawig, Jr., M.D., Spirit Lake. Lower right, J. E. Tyrrell, M.D., Manchester, 1970 Annual Meeting program chairman, visits with Otto F. Otepka, Washington, D. C., member of the Subversive Activities Control Board and an Annual Meeting speaker.





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Scientific Articles

Massive Hemothorax Caused by Bleeding From an Intercostal Artery

PAUL T. DAVIDSON, M.D.
Denver, Colorado

THE USUAL CAUSE OF HEMOTHORAX is trauma to the chest. Occasionally, hemothorax occurs without trauma. Diagnosis under this circumstance often is difficult since the etiology may not be readily apparent. Such was the case in the patient described here who developed massive hemothorax without evidence of trauma and who required surgery for treatment. The cause of the bleeding and the amount of the bleeding which occurred are unusual.

CASE PRESENTATION

History: A 70-year-old retired painter was admitted to the Veterans Administration Hospital, Iowa City, Iowa for the fifth time on September 27, 1965 because of progressively increasing shortness of breath during the week before admission. He denied fever, chills, hemoptysis, cough, chest pain, ankle edema or orthopnea. There was a past history of many years of shortness of breath diagnosed as emphysema. The shortness of breath suddenly became much worse several days before his admission. There was no history of trauma to the chest.

The past history also included cigarette smoking, one to two packs daily for many years, but not for the previous nine years due to difficulty in breathing. The patient had influenza in 1918. In 1961 he was hospitalized because of spontaneous rupture of the bulbous membranous urethra and required surgical repair. A chest x-ray was compatible with diffuse interstitial pulmonary fibrosis. The patient denied having worked in mines or having been a welder or molder. In 1963 a diastasis recti was repaired. In 1964 he was hospitalized for diplococcal pneumonia and hiatus hernia. A chest x-ray (Figure 1) was similar in appearance to that taken in 1961. Bronchoscopy was normal. A PPD skin test was positive but sputum examination was negative for tuberculosis.

Physical Examination: The patient was an obese pale elderly man in obvious acute respiratory distress. The blood pressure was 110/69, the pulse 100/min. and regular. There was an increased anteroposterior diameter of the chest with poor expansion particularly on the left. The entire left chest was dull to percussion with markedly decreased or absent breath sounds. The abdomen was slightly distended. There was no organ enlargement or

Dr. Davidson prepared this report while serving as a Fellow in Infectious Diseases at the U. of I. College of Medicine. He is now staff physician in chest medicine at the National Jewish Hospital and Research Center, Denver, Colorado.

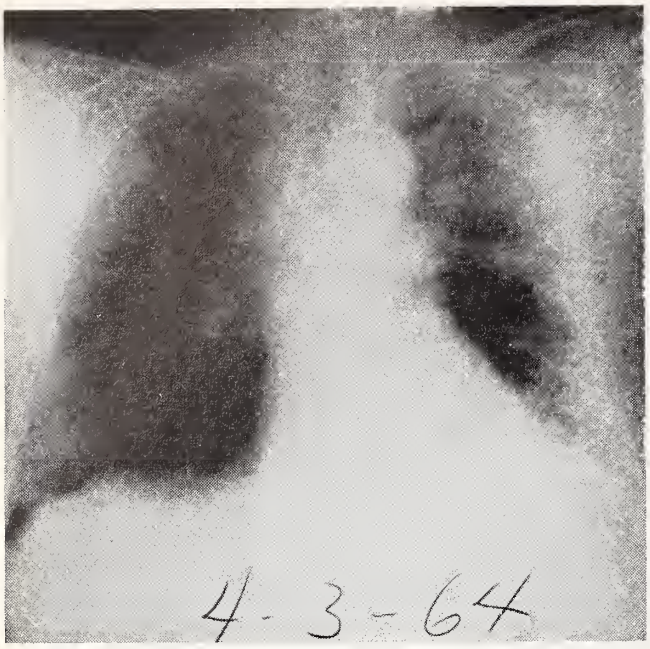


Figure 1. PA chest x-ray taken before the occurrence of hemothorax. Diffuse interstitial pulmonary fibrosis can be seen bilaterally.

masses palpable. There was a trace of pitting ankle edema.

Laboratory Results: Admission values were as follows: Hemoglobin 8.5 gm. per cent, hematocrit 27 vol. per cent, white blood count 25,000, with 79 segmented cells, 6 bands, 11 lymphocytes and 9 monocytes. Sputum cultures grew normal flora. The urine was packed with white blood cells. X-rays of the chest revealed complete opacification of the left chest with a shift of the heart and mediastinal structures to the right (Figure 2).

Clinical Course: On the day of admission a thoracentesis was performed with 1,600 cc. bloody fluid removed which did not clot. Not all of the fluid was removed. The hematocrit of the fluid was 22 vol. per cent and the hemoglobin 6.4 gm. per cent. The patient's blood pressure fell during the procedure. He was transfused with a total of four units of blood during the next 24 hours. The blood pressure returned quickly to the pre-thoracentesis level.

The second day, 1,600 cc. of bloody fluid was again removed from the chest. The patient's hemoglobin was 8.2 gm. per cent and the hematocrit 28 vol. per cent before thoracentesis. The patient continued to receive blood by transfusion.

On the third day after admission the hemoglobin was 7.8 gm. per cent and the hematocrit 27 vol. per cent despite continued transfusion. Three thousand cc. of bloody fluid was removed in preparation for thoracotomy. Thoracotomy was delayed, however, until the next day. During the induction of anesthesia, the patient developed bradycardia and impending cardiac arrest. A rapid thoracotomy was done on the left. Two thousand cc. of blood were removed from the pleural cavity. A bleeding intercostal artery was found near the posterior angle of the incision but not involved in the incision. This was believed by the surgeon to be the most probable site of bleeding as careful inspection of the entire thorax failed to reveal any other evidence of bleeding or any gross neoplastic process. The artery grossly appeared normal and was ligated. The lungs were noted to be markedly fibrotic but with a normal pleura and no evidence of adhesions. A lung biopsy was taken.

Postoperatively, the patient did well except for some anemia and temporary temperature elevation. He received a total of 17 units of

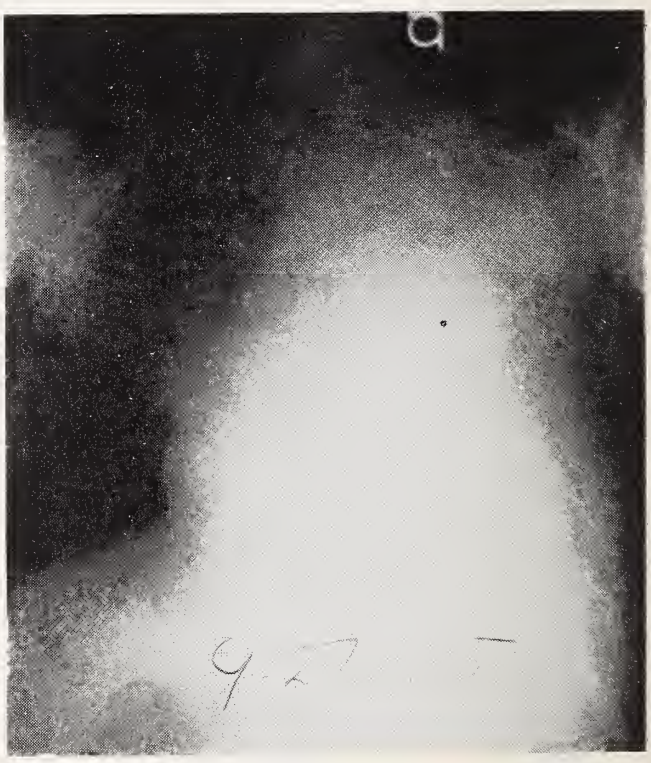


Figure 2. PA chest x-ray taken on admission showing complete opacification of the left chest with displacement of the mediastinum to the right.

blood during his hospitalization. On discharge, his left lung was well expanded. His hemoglobin was 10.7 gm. per cent and hematocrit 36 vol. per cent. He was given iron orally. One month following discharge he was doing well with a hemoglobin of 12.5 gm. per cent and hematocrit of 41 vol. per cent.

The lung biopsy was interpreted as showing a lung architecture almost totally altered. A few remarkably well preserved bronchioles lined by ciliated epithelium were present. There was surrounding fibrous tissue with irregular clefts. Scattered cysts and numerous lymphocytes and macrophages were present. There was no evidence of malignancy. Grossly the tissue was firm. Cut section revealed dense gray tissue with small cavities. All these changes were considered to represent "end-stage" bronchiectasis.

The patient was subsequently readmitted to the Veterans Administration Hospital, Iowa City on January 27, 1967 for treatment of mild congestive heart failure and left chest pain. He was noted to have had an abnormal glucose tolerance test. Further investigation of his pulmonary status was undertaken. A bronchogram revealed evidence of extensive chronic bronchitis. Generalized cylindrical bronchiectasis was noted in the lower lobe segments bilaterally. Pulmonary function tests were consistent with pulmonary emphysema and fibrosis with fibrosis being the dominant contributory factor. Chest x-rays (Figure 3) revealed diminished lung volume on the left with increased pleural thickening. He was treated with digitalis, salt restriction and an oral hypoglycemic agent.

The patient's last admission was on May 12, 1967 two weeks after his previous discharge. In addition to his previous diagnoses, it was felt that he had a chronic brain syndrome and chronic pyelonephritis. He was treated with antibiotics in addition to his other medications, and was discharged to a nursing home on June 28, 1967. He died suddenly at the nursing home on July 5, 1967. No post-mortem examination was performed.

DISCUSSION

Massive bleeding developed suddenly and without obvious trauma and without obvious etiology in this patient. A hemothorax can occur as a result of a multitude of intrathoracic conditions unrelated to trauma, but generally the amount of the bleeding is not as great as seen in this patient. A ruptured thoracic aortic aneurysm could produce such a massive amount of bleeding and would generally be rapidly fatal. Other conditions such as pleural mesothelioma or pulmonary infarction can cause significant hemothorax but again the amount of bleeding would generally be less than seen here and the clinical findings would probably suggest their presence.



Figure 3. PA chest x-ray taken 16 months after hemothorax. The fibrotic changes remain the same. There is a diminished lung volume on the left and evidence of increased pleural thickening.

This patient was known to have significant pulmonary disease which later was documented by lung biopsy. Pneumothorax can occur in patients with chronic fibrotic or emphysematous lung diseases. Hemothorax following pneumothorax has been reported and is said to occur in about five per cent of all cases of spontaneous pneumothorax.[1-3] The bleeding probably results from tearing of pleural adhesions or pulmonary blood vessels during a pneumothorax. Hartzell[1] reviewed hemopneumothorax in 1942. He was able to find only 43 cases reported in the world literature in approximately 100 years including three of his own. He excluded cases associated with tuber-

culosis or malignancy. All the patients were male except one and all except five were between the ages of 20 and 40 years. Fourteen cases ended fatally. Fry et al.[3] in 1955 compiled a tabulation of 174 cases of hemopneumothorax reported in the literature up to that time. The male sex predominance and the 20-40 year age range were again noted. Jones et al.[4] emphasized that in most instances of hemopneumothorax there tends to be a sequence of events consisting first of sudden severe chest pain and dyspnea followed by temporary improvement lasting hours or days, then recurrence of pain with dyspnea and appearance of signs of hemorrhage. Occasionally the symptoms may be predominantly abdominal rather than respiratory.

Although the presented patient had extensive pulmonary disease, primarily fibrosis, his clinical history does not follow the sequence of events as suggested by Jones. There was no pain, the symptoms became progressively worse, the patient was not in the usual age range for hemopneumothorax reported by Hartzell[1] and Fry,[3] and at thoracotomy no evidence of bullae or adhesions was present. A bleeding intercostal artery was found and ligated. No other cause of bleeding was found. Because of the clinical history and the lack of air in the chest, a pneumothorax seems unlikely although a small one may have occurred with rapid resolution. The patient may have sustained injury to his chest which he did not recall and which was not apparent on examination but which may have contributed to the rupture of the artery. Unfortunately, no biopsy material was taken from the bleeding artery for investigation of possible causes of the rupture. The artery grossly was considered normal. The patient did not have clinical evidence of Marfan's syndrome, extensive arteriosclerosis of the peripheral vessels or syphilis which might explain an abnormal tendency for arterial rupture. There was no evidence of a blood dyscrasia or coagulation defect. If the artery was indeed normal, it is likely that it had sustained either trauma from outside the chest or more likely in association with the underlying lung disease. Despite the lack of evidence at surgery for adhesions the arterial rupture may have resulted from the tearing of an adhesion.

Surgical intervention was necessary in this case to stop the bleeding. In situations where the bleeding is less extensive as in the usual case of hemopneumothorax, conservative measures of treatment may be successful. Repeated thoracentesis probably should be done to avoid formation of a fibrothorax although Condon[5] has recently shown experimentally in dogs that if the parietal pleura is normal, as may be the case in simple spontaneous hemopneumothorax, clotted hemothorax is absorbed without formation of fibrothorax. Several authors[6, 7] have reported the successful use of intrapleural enzymes in the treatment of clotted hemothorax. Pearse and Nelson,[8] however, were unable to show any effect of fibrinolysin on resolution of induced hemothorax experimentally in dogs.

SUMMARY

A 70-year-old male patient with extensive fibrotic lung disease developed massive left hemothorax unrelated to trauma and without evidence of pneumothorax. Thoracotomy was necessary to control the bleeding. A bleeding intercostal artery was found and ligated and was thought to be the only source of bleeding. No apparent explanation for the ruptured artery was found, but it was postulated that it was caused by tearing of a pleural adhesion possibly in association with a small pneumothorax, although evidence for both was lacking.

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A Capsule Review of Mental Retardation

WALTER M. BLOCK, M.D.
Cedar Rapids

In the introduction to his book mental retardation in infants and children, the late Abraham Levinson, M.D., stated:

"Some of our finest and most efficient physicians have been guilty of indifference to the problems of the mentally retarded child and his parents. Many of them do not appreciate the effect of their actions on the family of such a child. Few physicians are aware of the grave responsibility that is theirs when they are called upon to treat a child whose mentality is questionable."

If this statement is true—and I certainly believe that it is—there is need for dissemination of knowledge concerning mental retardation.

It is believed that 3 per cent of all newborn infants will at some time in their lives be diagnosed as being mentally retarded. Although approximately 200 conditions have been identified as possible causes of retardation, 50 per cent of the retarded children are without an etiologic diagnosis.

Of the total group of retarded children (Table I), about 85 per cent are educable retarded, which means that the highest mental age they will reach is that of a 12-year-old child. Another 11.5 per cent belong in the group of moderately retarded or trainable children. These youngsters cannot be taught the usual "three R's," but they can and should attend classes for trainable retarded children. They will attain a mental age somewhere between 3 and 7 years. The remaining 3.5 per cent will be severely retarded and more or less totally dependent all their lives. It is estimated that about 7 per cent of all school children are mentally subnormal. The magnitude of the problem becomes obvious by looking at these figures.

There are many different etiologic classifications of the mentally subnormal child; frequently encountered is one relating to birth factors, so that one may speak of antenatal, prenatal and postnatal causes (Table II).

TABLE I

CLASSIFICATION BY I.Q.

	I.Q.	Per Cent of Population	Per Cent of M.R. Population
Average Mentality ...	90-110	50	—
Dull-Normal	80-89	16	—
Borderline	70-79	7	—
Mild M.R. (Educable) (M.A. 8-12 yrs.) ...	50-69	2.5	85.0
Moderate M.R. (Trainable) (M.A. 3-7 yrs.)	30-49	0.4	11.5
Severe M.R. (M.A. 0-2+ yrs.) ..	0-29	0.1	3.5

TABLE 2

CLASSIFICATION OF M.R.

1. Antenatal (genetic) factors
 Retardation initiated before birth, including so-called "congenital," "familial," "hereditary" types
2. Prenatal causes
 Due to factors of pregnancy
3. Paranatal factors
 Birth accidents
4. Postnatal causes
 Infection, trauma, toxic agents

Dr. Block is the medical director of the Child Evaluation Clinic, Cedar Rapids.

Among the genetically determined, antenatal causes, familial mental retardation is by far the largest group; it is also sometimes called the subcultural group.

Phenylketonuria and other metabolic causes of mental retardation fall into this category. Prenatal influences of known cause include such conditions as maternal rubella, kernicterus or cretinism. Prenatal mental retardation also stems from such causes as toxemia, prematurity and anoxia. Birth injuries, such as cerebral trauma, are classic examples. Infections such as encephalitis, toxicity due to lead poisoning, and head injuries are some of the more common postnatal causes of retardation.

A carefully-taken history and meticulous examination generally will uncover several significant points if mental retardation is present, such as: abnormal physical appearance, especially the often characteristic facies of the mentally retarded child; delayed neuro-muscular development, as indicated by delayed developmental milestones; subnormal responsiveness to the environment; convulsions; slow learning; hypo- or hyper-activity; lack of concentration power (poor attention span); speech and language problems, especially delayed speech acquisition; possibly visual and/or hearing defects (slightly impaired hearing is found frequently in retarded children); certain types of paralysis, as found especially in the cerebral palsy child; and rather frequent presence of emotional problems (Table III).

The diagnostic work-up should include routine blood counts and a urinalysis. One should remember that leukemia is found more frequently in children with Down's Syndrome than in the general population. A serologic test for syphilis should be done routinely in order to rule out congenital lues. DNPH and nitroprusside tests for amino-acidurias are relatively simple to do and can rule out a number of metabolic causes for mental retardation, especially PKU and homocystinuria. An x-ray film of the skull should be obtained to identify calcifications such as one might find in toxoplasmosis. An EEG is indicated primarily in the child with a history of convulsions. PBI or T3, to rule out hypothyroidism, and a blood sugar to rule out hypoglycemia are two important laboratory tests (Table IV).

Concerning the care of the retarded child and his family, there are a number of factors which should be discussed with the parents. These must be followed through the years by those entrusted with the care of a mentally subnormal youngster (Table V).

Initial as well as continuing counseling for the parents is of utmost importance to the entire family constellation. Medical supervision and treatment should be the same as for any other normal child, including routine immunizations. Administration of measles and mumps vaccine is important, if for no other reason than to prevent the possibility of an encephalitis caused by these viruses. The need for surgery, such as the repair of a cardiac

TABLE 3

CHARACTERISTICS OF M.R. CHILD

1. Abnormal physical appearance (esp. facies)
2. Delayed neuro-muscular development
3. Subnormal responsiveness to environment
4. Convulsions
5. Slow learning
6. Hyper, or hypo-activity
7. Lack of concentration
8. Speech problems
9. Defective hearing and vision
10. Weakness or paralysis
11. Emotional problems

TABLE 4

LABORATORY TESTS

Blood Count
Urinalysis
Serologic test for syphilis
DNPH & Nitroprusside tests for amino-acidurias
Skull X-rays
EEG
PBI or T_3
Blood Sugar

TABLE 5

PROGRAMING FOR THE M.R. CHILD

1. Counseling parents
2. Medical care for child
3. Nutritional care for child
4. Directions for proper child-rearing practices adjusted to the M.R. child
5. Educational planning
6. Pro's and con's of custodial care
7. Directions for relationship with peers
8. Planning the child's future

defect for a child with Down's Syndrome, must be as carefully considered as for a normal child. Nutritional care should include particular attention to the problem of obesity, as it is frequently encountered in older retarded children.

If the parent with a normal child is often in need of advice concerning proper child rearing practices, so too is the parent with a mentally retarded child. The methods employed generally can be essentially the same as those applied to the normal child; however, advice has to be tailored individually to the needs and the limits of the retarded youngster.

A good educational program must be planned early and not just at school age; this includes paving the way for the family to enroll the child in programs available in the community.

The question of home care versus custodial care must be tactfully discussed with the parents of the severely involved child. The time to do this must be carefully selected. Relationships with other children in the neighborhood must be intelligently planned and supervised, and finally, proper vocational planning for the youngster's future must be discussed when the time arrives.

This *capsule review* of mental retardation hopefully will give the reader an idea of the problem he is facing when he accepts the responsibility of caring for a retarded child. Through the communications media, the public has had access to much information on the subject of retardation. It therefore behooves those of us who care for mentally retarded children to acquire the necessary knowledge to allow us to discuss this problem intelligently with parents.

A Case Report: Occupational Exposure to the Insecticide Naled

DAVID L. MICK, Ph.D.,
THOMAS D. GARTIN, M.D., and
KEITH R. LONG, Ph.D.

AS THE CHLORINATED HYDROCARBON INSECTICIDES come under closer scrutiny each year, it is to be expected that other chemicals will replace them in many situations.[1] Such is the case in urban areas of Iowa where DDT has been used as the primary insecticide for mosquito control. The advantage of its residual properties for insect control also has been the cause of its demise because of the build-up in the environment.

Naled (1,2-dibromo-2,2-dichloroethyl dimethyl phosphate) has found favor in Iowa for aerial mosquito control as a substitute for DDT. This organophosphate insecticide is often sold under the trade name Dibrom®. It is less toxic than most organophosphate insecticides with a slightly higher toxic potential than malathion.[2] In experiments using rats, the acute oral LD_{50} of technical naled was 430 mg/kg, while rabbits were used to obtain an acute dermal LD_{50} of 1100 mg/kg for the technical material.[3] The product is of low volatility with a vapor pressure of 0.0002 mm Hg at 20° C.[3]

As a group, the organophosphate insecticides

Dr. Mick is an assistant professor, Institute of Agricultural Medicine, College of Medicine. Dr. Gartin is a private practitioner, Ames, Iowa. Dr. Long is a professor in the Institute of Agricultural Medicine. The Iowa Community Studies Pesticides Project is supported by Contract No. 86-66-52 with the Division of Community Studies, Office of Product Safety, Food and Drug Administration, Consumer Protection and Environmental Health Service, Public Health Service, Department of Health, Education and Welfare, Atlanta, Georgia.

act as irreversible inhibitors of the enzyme cholinesterase. Organophosphate insecticides are absorbed by the respiratory and gastrointestinal tracts and also by the skin. Because compounds like naled are only slightly soluble in water, they are difficult to remove and, therefore, the exposure may be prolonged. There is, of course, increased absorption and greater chance of skin reaction or more serious complication. It should not be forgotten that a skin reaction, or any dermatitis, greatly enhances absorption of the insecticide.

The case in question involved an aerial applicator using naled (1 oz/acre) for urban mosquito control. His contact with the insecticide came in the ground operations necessary for maintaining a spray plane. Elbow-length rubber gloves were worn with a short-sleeved shirt in the insecticide loading operation. They also were worn while cleaning the nozzles, washing the plane, etc. A hole in one glove allowed entry of the insecticide to the hand. A rag was used to wipe off the hands and forearms after the exposure was noticed, and this probably did more to spread the chemical over the skin area than to remove it.

Other instances of known contact with the insecticide include: (1) An applicator who, while crouching down on the ground, had a knee come in contact with an area where some of the chemical existed. (2) Spillage on the shoe of an applicator followed by a walk in wet grass resulted in a skin reaction to the foot. (3) A drop of the insecticide fell accidentally from the boom area of the sprayer onto an applicator's back.

The areas of body exposure initially became erythematous with a burning sensation followed by vesicular blisters that were often edematous. After this stage the blisters dried up, itched severely and flaked off. The hands and forearms showed the most severe reaction (Figure 1). Swelling of the hands was common. After decreased exposure and treatment with a cortisone cream, the patient recovered in three weeks.

This case is an example of contact dermatitis resulting from exposure to naled. Similar situations have been previously reported although the specific chemicals have not been mentioned.[4] In a research report, naled was reported to be a dermal irritant but not a sensitizer.[5]

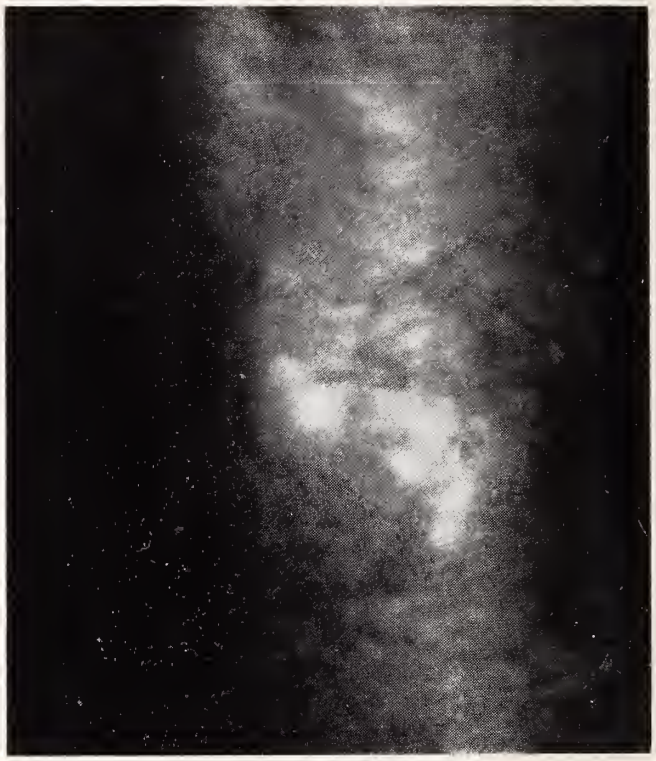


Figure 1. Blisters on the left hand and forearm resulting from Dibrom exposure. (Photograph courtesy of Dr. Harold Gunderson, Iowa State University, Ames, Iowa).

This irritating property may be a safety factor if it prevents prolonged exposure that could result in a more serious condition than dermatitis.

SUMMARY

This case report serves as an example of what can develop in a situation originally thought to be an incidental dermal exposure to naled. The exposure produced cutaneous problems serious enough to warrant medical attention. Physicians should be alert for this type of situation, as well as cases where a dermal irritant may be lacking and may result in a prolonged exposure and more serious complications.

The opinions expressed in this article are the authors' and do not necessarily reflect the views of the Food and Drug Administration or the Department of Health, Education and Welfare. Trade names are used for identification only and do not represent an endorsement by the FDA or HEW.

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The Medical Approach to Male Homosexuality

RICHARD A. TRUAX, M.D.,
WILLIAM S. MOELLER, M.D., and
GARFIELD TOURNEY, M.D.
Iowa City

THIS DISCUSSION AIMS at acquainting the physician with the problem of male homosexuality and the medical approach to its etiology and treatment. Manifestations of neurotic conflict are often associated with this personality difficulty, and they include anxiety, depression and chaotic interpersonal relations. Homosexuality represents not simply a way of life or deviant behavior, but an arrested state of personality development. As such, it should be viewed as important a challenge to the physician as failures of physical development and function. Individuals with this problem may rise above their disability and function in an effective and creative manner. An individual's attempt to compensate for his difficulty may be admired, but an attempt to glorify the handicap itself, as many homosexuals do, denies many basic problems.

I. GRADATIONS OF HOMOSEXUAL PERSONALITY DEVELOPMENT

Attraction of males toward one another is not uncommon, especially in the latency period between 6 and 13 years of age when boys prefer the company of their own sex. Boys who play with girls during this time of life are often regarded as effeminate and *sissy*. Curiosity and preoccupation with individuals of their own sex are common, and exploratory behavior involving the display and examination of the genitalia may occur. Essentially, this behavior represents a normal stage of male identification and personality development.

The authors are members of the Department of Psychiatry, U. of I. College of Medicine.

Admiration and desire for male friendship may lead to physical gestures of affection, such as a couple of friends embracing or walking down the street together holding hands. This is frequently accepted as normal in childhood. In adult society the handshake is an acknowledged greeting between men in our culture. In other cultures males are sometimes more likely to embrace or kiss each other on meeting. Although a culture may decree that certain of these habits are acceptable patterns of behavior, and consider other behavior as homosexual, there is actually no clearly defined line where homosexuality as a sexual perversion begins. Common interests among boys in the latent and early adolescent age groups include a curiosity regarding the size and development of other male genital organs along with a certain amount of sexual exploration, such as comparing the genital organs or masturbating together. Provided the boy feels secure and accepted by his parents and peers, these interests usually fade in early adolescence when the youth's primary interests turn increasingly toward girls.

Other pubescent boys, especially those who feel left out or inadequate, may be dissatisfied with the role defined by their culture as the proper one for males. They may have homosexual phantasies and participate in homosexual activity. Although they may be actually rejected by their peers, homosexuals are more frequently confronted with the subjective feeling of being left out, unacceptable to or different from others. These youths may be preoccupied with their phantasies to the detriment of other areas of functioning, such as school and social activities. These preoccupations, recognized as abnormal and perplexing, are associated with a feeling of guilt and anxiety. Overt homosexual behavior, including anal intercourse, fellatio and mutual masturbation, may occur with peers or older males having similar desires. Sexual relationships with men

serve as a substitute for male companionship, acceptance, and a healthy father-son relationship.

These adolescent males often are unhappy with their homosexuality and demonstrate bisexual tendencies, as seen in some degree of heterosexual desires, dating, and eventual plans for marriage. Throughout adolescence and early adulthood they experience guilt, fear and sexual confusion. They may attempt to question their peers or parents about their feelings, but usually decide their emotional state is not to be discussed. If they do talk about their problems, they often find such severe rejection that they elect to remain silent. In self-contempt and shame they isolate themselves from former friends, and they are increasingly drawn to those who have experienced a similar kind of difficulty. Individuals who are depressed and anxious about their conflicting homosexual and heterosexual impulses are likely to benefit from psychotherapy.

A more fully developed form of homosexuality is represented by a persistent preference for males as sexual objects. This preference often begins with the earliest memories and continues more or less consistently throughout life. Most of these men regard their homosexuality as natural and beyond their control. When treated with intensive psychotherapy, they reveal deep feelings of inferiority, a dissatisfaction with their body or physique, inadequacy in sports or other masculine endeavors, as well as intense self-preoccupation. These feelings are partially compensated for by finding masculine acceptance through homosexual relationships in which they attract men who, they believe, have qualities that alleviate their real or imagined inadequacies, especially when they are young.

Sexual contacts are characteristically short-lived and transitory; with advancing years they find increasing difficulty obtaining homosexual contacts and their lives become more bleak and lonely. Most homosexual individuals are not sexually assaultive, sadistic or dangerous, and they frequently, through their vocations, make worthwhile contributions to the society in which they live. Although some homosexuals may be identified on the basis of effeminate behavior, many homosexuals appear to be very masculine. Also, some men with effeminate mannerisms are completely heterosexual in their sexual orientation.

II. ETIOLOGY OF HOMOSEXUALITY

On investigation, the patient with homosexuality reveals an impaired self-concept, a feeling of being different from other males, and poor peer relations during childhood. However, it is necessary to go back further in personality development in order to study and trace the origins of homosexuality. A look at the configuration of loyalties within the family structure is necessary and includes the frequently covert and subtle means utilized by the parents to control the child's development of interests and behavior patterns. Absence of satisfactory father-son relationships characterize the early conflicts. The father is sometimes viewed as cruel, suppressive and unreasonable, but more frequently as weak and ineffectual. Although an assertive, reliant, concerned father is an aid in male identification, many fatherless children mature completely masculine. They are the products of a proper relationship with their mothers, peers, and suitable objects of male identification.

One feature nearly always present in homosexuals is an overly close mother-son bond, especially in early childhood, but often persisting and continuing into adulthood. These dependencies upon the mother develop in many ways. They include such mechanisms as (1) a mother's subtle undermining of her child's growing self-concept as a male, (2) the shielding of a son from peer competition, (3) encouraging feminine interests, and (4) depreciating the father in the child's presence. Such a mother often neglects the husband and brings her personal problems to her son, who serves as a reluctant confidant as well as a source of affection. The son becomes his mother's personal companion, and she expects him to spend time with her to the exclusion of either his peers or his father. Such maternal behavior has many sexually seductive overtones for the son.

At other times these boys appear to dominate their mothers. These young men may become self-centered with their mothers serving their every need. Careful study will often reveal actually that they are completely dependent upon their mothers; no one else will accept the kind of behavior they exhibit. As a con-

sequence of this overly close mother-son bond, to the exclusion of other meaningful emotional relationships, this child establishes a poor sense of his own identity. He is increasingly troubled by the development of sexual feelings, which are difficult for him to control. Unlike others who identify with their fathers, have peer relationships and feel adequate with girls, his sexual feelings are directionless other than toward his mother or males with whom he would like to identify narcissistically. Thus homosexuality comes to the fore as a means of seeking male companionship and identity, as well as a means of escaping from incestuous fears originally directed toward the mother. Homosexuality represents both a search for male identity and an escape from incestuous fears. Fear and apprehension regarding heterosexuality become generalized to include all women.

Other contributing causes to homosexuality include the effects of early conditioning to sexual response. Occasionally, homosexuality may be related to seduction by an older male. Once initiated into homosexual behavior the individual may tend, with increasing repetition, to find this more and more pleasurable. This reinforcement of pleasurable behavior may fix the pattern of sexual outlet for the potentially homosexual youth, particularly when coupled with the previously described pychodynamics.

Closely related to the psychodynamic factors are sociocultural issues. These include the availability of a homosexual subculture as well as society's harsh, condemning attitude toward homosexuality. The later moves individuals into the homosexual subculture in a search for acceptance and understanding.

Although genetic factors exist that may make some people more vulnerable to homosexuality than others, a review of the limited nature of homosexuality in the animal kingdom, together with the fact that chromosomal females may identify and develop sexually into heterosexual males, mitigates against considering homosexuality as being primarily determined on a genetic basis.

III. EMOTIONAL SYMPTOMS ASSOCIATED WITH HOMOSEXUALITY

Homosexuals frequently have neurotic symptoms which may be exaggerated responses to the normal stresses of life. These symptoms may be related to an impending breakup with a homosexual partner or to a feeling their life is empty and devoid of meaning. Furthermore, neurotic symptoms may occur without any clear-cut precipitating factors. Among these neurotic symptoms, anxiety and depression are commonly observed. The manifestations of anxiety may be psychophysiologic, such as excessive perspiration, cold, clammy hands, fatigue, weakness, tension headache, tachycardia, palpitation, hyperventilation and gastrointestinal symptoms. Elements of depression may appear, such as depressed mood, blueness, apathy, sleep disturbance, increased irritability and weight loss. Sometimes a need to avoid anxiety-arousing situations develops, leading to a phobic avoidance response. At other times, an excessive concern about homosexuality results in intense guilt, isolation from others and an increasing attempt to control homosexuality by simple suppression rather than by homosexual acting out or sublimation. The result is a paradoxical intention in that the harder the homosexual tries to overcome his feelings, the worse the situation becomes. These neurotic symptoms frequently respond favorably to psychotherapy.

On other occasions, some homosexuals develop near-psychotic or frank psychotic reactions. Among these is homosexual panic, which frequently occurs in an individual who is not overtly homosexual but has strong unconscious homosexual conflicts. Following exposure to a homosexual stimulus or when forced into heterosexuality, these individuals find themselves overwhelmed with unacceptable homosexual feelings to which they respond with extreme anxiety or panic, partial breakdown of ego function, and confusion. Although these states are dramatic and suicide constitutes a real possibility, they tend to resolve within a few days with appropriate treatment. Occasionally a similar disturbance of ego function can be found in overt homosexuals when faced with an impending termination of a homosexual relationship. These reactions are generally not as severe as homosexual panic, and usually more appropriately considered to be neurotic or acute stress reactions. Depression is often the most important symptom component in this situation, and acute suicidal impulses may be present in the patient with or without suicide attempts.

Schizophrenic patients may complain of homosexual feelings. Such concern may be a presenting symptom in an initial schizophrenic attack. The differential diagnosis from homosexual panic depends on the presence of primary schizophrenic symptoms such as the disturbance in association of ideas, presence of inappropriate affect, autistic thinking, disturbances in attention and ambivalence. Where a breakdown of ego function occurs, suicide is a distinct possibility and this necessitates hospitalization and prompt treatment with substantial doses of phenothiazines in most cases.

IV. HOMOSEXUALITY AS A SYMPTOM VERSUS HOMOSEXUAL SUBCULTURE

Active homosexuality is somewhat effective as a defense against ego insult and unresolved psychodynamic problems. As such it may be ego syntonic for certain individuals who have developed rationalizations to support and glorify their homosexuality. These men move about freely in the homosexual subculture which becomes a transitory and illusory haven in which some degree of sexual gratification, personal understanding and acceptance may be found. These individuals usually do not seek treatment unless confronted with some crisis in acting out their homosexuality. Such crises include a break-up with a homosexual partner, the perception of the ultimate shallowness and transitory nature of homosexual relations, and/or confrontation with a legal problem as a consequence of their homosexuality. In contrast a considerable number of homosexuals are grossly dissatisfied with their homosexuality, and either abstain completely from overt homosexual behavior or move only on the fringes of the homosexual society. To these men homosexuality is rarely or never ego syntonic.

V. DEVELOPING A THERAPEUTIC ATTITUDE

A society that makes homosexuality unmentionable retards development of a rational understanding of the problem. Increasing discussion and study of the problem have been possible in recent years. Only when homosexual thoughts and behavior are regarded as human problems that can be discussed, rather than as a taboo subject, is it possible for the individual to say to himself, "Yes, I have a homosexual problem." He is then ready to seek treatment in order to understand its origins and implications for him.

Although this is partly a problem of public reeducation and law reform, it is also an attitude that the physician needs to acquire in order to consult with and treat the patient, and when indicated, the patient's family. Especially for young men, a feeling of being accepted and understood can help to facilitate healthy personality development; by contrast the promotion of guilt and confusion may lead to withdrawal from help and suitable relationships. Homosexuality for many men is a fluctuating phenomenon. It tends to intensify at times of ego insult and may lessen with establishment of male companionships or following acceptance as a man by a woman. Thus, although in many respects homosexuality is a chronic condition, it has exacerbations and remissions. Some of these men, especially those who are young and well motivated, may benefit from referral to a psychiatrist for psychotherapy.

For many, because of poor motivation, lack of insight or advancing years, psychotherapy will not be indicated nor will treatment be accepted by the patient. Many of these men manage without professional help. Others will require occasional supportive treatment when faced with a personal crisis.

VI. PSYCHIATRIC TREATMENT

Although there has been considerable controversy among psychiatrists as to the treatability of homosexuality, it is our opinion that a large number of patients with homosexual conflicts can be helped through psychotherapy. Such treatment may not necessarily alter the sexual orientation, but many of the associated neurotic and interpersonal difficulties can be resolved; this will permit the individual to live a more satisfying and productive life. Psychotherapy, both individual and group, remains the most effective treatment approach. Minor tranquilizers, such as diazepam (Valium), chlordiazepoxide (Librium), or meprobamate (Miltown or Equanil) are sometimes helpful in the symptomatic treatment of anxiety and its derivatives. Although homosexuals may develop a genuine psychotic depression and require antidepressant medications, depressive symptoms tend to be reactive and transitory in most instances.

The general physician's attitude toward the

patient's problem may be decisive in getting the patient involved in the necessary psychiatric treatment. Allowing the patient to ventilate his feelings in a nonjudgmental setting and dealing with the family crises related to the problem are important steps in the eventual referral for specialized psychiatric care.

Homosexual panic may require the use of sedatives and at times intramuscular phenothiazines. With severe panic and suicidal tendencies, hospitalization is indicated. Sometimes it is difficult to distinguish this panic state from an acute schizophrenic break. When a homosexual patient comes requesting help, it is best to determine if the problem is of recent origin. If a previously heterosexual man becomes concerned about homosexual impulses, and especially if these are associated with feelings of extreme anxiety and/or confusion, this may be an indication of an impending schizophrenic break. Paranoid individuals may present with a complaint that they or their friends are homosexual.

Testosterone increases the intensity of sexual drive but does not change its object choice. Estrogens decrease sexual drive and with prolonged usage bring about secondary feminizing characteristics. Hormones play no significant role in the treatment of homosexuality.

Intensive individual psychotherapy usually involves appointments of approximately an hour on one to several days a week over a period of months to several years. Free association and other psychoanalytic techniques are frequently employed. One aims at exploration of the basic psychodynamic mechanisms leading to the development of the illness. Current behavior is understood in terms of these underlying determinants, and the goal is a more effective life adjustment. Although costly and time consuming, this method is sometimes effective in changing sexual orientation.

Recent interest has been directed toward group psychotherapy with exclusively homosexual groups, as exemplified in Hadden's publications beginning in December 1966. In a search for a more practical and effective treatment method we decided to organize an initial group therapy program of five self-referred homosexual patients. We were impressed with the similarity of problems among group members and the degree to which they could empathize and identify with one another. Homosexual attraction between group members was seldom a problem. Instead, the group provided an opportunity for friendship on another basis —one of emotional understanding. Homosexual drive declined, anxiety decreased, group enthusiasm persisted, patient attendance was high, and at the end of the first year none of the five had discontinued treatment. The group was effective in breaking down taboos regarding homosexual preoccupation and personal difficulties among the patients. As the configuration of family loyalties was reviewed and early sexual phantasies recalled, unconscious psychodynamic material appeared early in treatment, either in dreams or in the group discussion. Such material rarely occurs otherwise except by means of free association in prolonged psychotherapy. The emotional responses expressed with this material were appropriate.

In the fall of 1967 a pilot study to determine the effectiveness of the treatment program was established. Thirty patients were self-referred; they were young, intelligent and well motivated. As such they represented better treatment subjects than one would expect in a random sample of the homosexual population. The only factor distinguishing the treatment and control group was the order of appearance at the outpatient service. Thus all those appearing after a certain date were placed in a control group. The groups met for one-and-a-half hours once a week. A self-administered questionnaire was given to the treatment and control groups at the beginning and end of a seven month period. The results indicate a significant reduction in homosexual phantasy activity for the patient group but not the control group. (See Table I.)

TABLE I

PER CENT OF SEXUAL PHANTASY DEVOTED TO HOMOSEXUALITY

	Treatment Group N = 20	Control Group N = 10
Prior to Starting Treatment	75	72
Last Phase of Treatment	57	65
Difference	−18*	− 7†

* t test significant at $p<0.05$.
† Not significant.

The waking hours devoted to homosexual preoccupation are illustrated in Table II. Again the treatment group shows a significant shift in that their homosexual preoccupation is reduced.

Although the subject's sexual orientation may not change, he may be less preoccupied with intrusive thoughts. For example, several of the treatment subjects showed a decrease in heterosexuality; however, they were less preoccupied with their homosexuality, more willing to accept themselves, and they considered their treatment highly beneficial.

Group psychotherapy also reduced neurotic symptomatology, improved the patient's self-concept and sense of personal well-being. The therapist's ratings on these two factors at the end of treatment are presented in Tables III and IV.

These Tables indicate that the treatment program has been effective in reducing neurotic symptoms and in increasing self esteem. The initial pilot study results are encouraging. The subjects appeared more able to establish effective social relations, heterosexual dating increased, and homosexual behavior was reduced. Several of the subjects were able to become intimately involved with women and gave serious consideration to marriage. Most subjects emphasized a marked to moderate reduction in their sexual conflicts but realized that further personality maturation was necessary before a complete resolution of their homosexual problem would occur. The treatment program is being continued on a more intensive basis with each group meeting for one-and-a-half hours twice a week. Other clinical measures are being assessed to further clarify the efficacy of the treatment. Some patients from the earlier treatment groups have continued in the current treatment program and are continuing to show even further progress. Although treatment is slow and complete resolution of homosexuality uncommon, our experiences over the past three years indicate that this type of therapy causes significant changes in personality functioning, including reduction of anxiety, elevation of mood, reduction of homosexual orientation and preoccupation.

TABLE II

PERCENTAGE FREQUENCY OF HOMOSEXUAL PREOCCUPATION

	Treatment Group N = 20	Control Group N = 10
Prior to Treatment	50	24
Last Phase of Treatment	20	24
Difference	−30*	0

* t test significant $p<0.01$.

TABLE III

NEUROTIC SYMPTOMATIC CHANGE— THERAPISTS RATINGS

	Treatment Group N = 20	Control Group N = 10
Worse	1	1
No Improvement	1	6
Slight Improvement	5	2
Moderate Improvement	7	0
Marked Improvement	5	1
Asymptomatic	1	0

TABLE IV

SELF CONCEPT AND SELF ESTEEM THERAPISTS RATING

	Treatment Group N = 20	Control Group N = 10
Worse	1	1
No Improvement	2	6
Slight Improvement	3	1
Moderate Improvement	7	1
Marked Improvement	6	1
Profound Improvement	1	0

SUMMARY

Homosexuality is the result of arrested personality maturation. It is dependent on a pattern of an overly intense mother-son relationship and ineffectiveness of the father as a male identification figure. It occurs in varying degrees over time and with improved self-concept and socialization tends to diminish. Homosexual conflict is associated with many symptoms of emotional disturbance as well as a problem in sexual orientation. The authors report on their experiences treating homosexuals in exclusively homosexual groups over the past three years.

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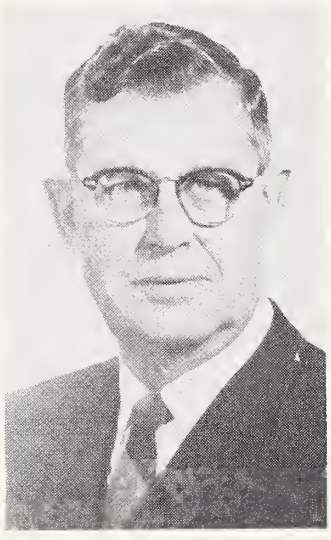
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Unveil Painting of Dr. Scanlon



PORTRAIT UNVEILED—The above portrait of the late George H. Scanlon, M.D., was unveiled in a ceremony April 22 at Mercy Hospital in Iowa City. Painted by Mrs. Cloy Kent of Iowa City, the portrait is a gift to the hospital from the medical staff. It will hang permanently in the new hospital lobby. Shown above, left to right, are Ronald Saf, Des Moines, executive secretary, Iowa State Board of Medical Examiners; Mrs. Scanlon, Iowa City, and Donald L. Taylor, Des Moines, executive vice-president, Iowa Medical Society. Dr. Scanlon died in 1969. He served as chairman of the Board of Medical Examiners, president of the Iowa Medical Society and was instrumental in the founding of the Scanlon Medical Foundation/Iowa Medical Society.

President's Page



The 1970 IMS House of Delegates provided a fine springboard for entry into what appears certain to be a very active year. The decisions of the House were historical.

The wheels turned to permit the admission of osteopathic physicians and surgeons into our ranks; to allow students in the College of Medicine to have representation in the House of Delegates; to make abortion a matter to be decided by the patient and the doctor and to permit its performance only in an accredited hospital; and to stress the importance of study by Society officers of the "foundation for health care" concept.

As your leader, I heartily support each of these actions. This aggressive posture will place our Society on the offensive. Iowa medicine must assume this forward look. We must pursue the questions of manpower, peer review and medical education.

President



Editorials

THE DANGER OF EXTREMISM

The protests, rebellion and violence on many of our college campuses are a serious concern to the American people for they jeopardize the academic community and interfere with those seriously engaged in procuring an education. They are a serious concern for they are in defiance of law and order and are contrary to the American way of resolving differences. It is ironical that violence is the instrument of protest against the violence the participants abhor and so vociferously decry. It is inevitable when mob and mob rule are confronted by the forces of law serious conflict results, and as is usually the case, it is the innocent bystanders who suffer the most serious consequences.

No one objects to the student's right to dissent in the classroom or on the campus. However, differences must be expressed through accepted and well understood channels and there must be authority and discipline, and order must prevail. Otherwise, there is chaos, and that is actually the state of affairs at many colleges, some of which have had to close their doors.

The rebellion and chaos are ascribed to protest against our participation in Vietnam and the recent exacerbation on campus is attributed to the spread of hostilities into Cambodia. It would seem that intelligent and imaginative American youth could voice their feelings and convictions in a more effective manner than by mob action. This raises the question of whether it has come about as a result of the idealism and the spontaneity of youth or whether they have been stirred into mob action by motives other than mere protest against an unpopular war and the ills of society.

Apropos this question, a recent article by J. Edgar Hoover, published in the December 1969 issue of the FORDHAM LAW REVIEW, deserves the thoughtful considerations of the American people. Mr. Hoover points out that extremism poses a dangerous threat to the integrity of democratic institutions and that every citizen should be concerned. The Students for a Democratic Society (SDS) is, for example, an organization predicated on a Marxist philosophy, "whose members have developed into embittered, vociferous revolutionaries who have ignited many campus insurrections . . . today SDS is a youth movement dedicated to a revolution of violence."

Mr. Hoover urges that society face up to the realities of SDS extremism. It must, however, be kept in mind that they are a minority on our college campuses. Every effort must be made to preserve the questioning of the many problems of our industrialized society by the sophisticated, intelligent and poised generation which includes the majority of students in college. Mr. Hoover asserts that the generation gap is really a communication gap and parents have a special obligation to establish and maintain dialogue with the oncoming generation. This communication should emphasize problems which concern youth today, such as the war in Vietnam, the draft, social problems, poverty, etc. He cautions that in discussions of SDS, many non-SDS, moderate students make legitimate protests about some of the key issues of the day, and we must not make the mistake of labeling them as extremists because we disagree with them.

It is emphasized that the way to combat extremism is not by counter-extremism. One of

Editorials continued...

the real dangers of SDS extremism is that it will provoke antidemocratic, even vigilante and illegal action against this minority group. SDS must be handled under due process of law.

Above all, according to Mr. Hoover, society must make a serious effort to correct its own weaknesses, and work to do it promptly, effectively and fairly. Young people rightfully hate hypocrisy and sham. The legal profession has a special obligation and it cannot ignore the indifference of SDS to the laws governing our democratic society. Mr. Hoover concludes with the statement, "America must face up to the challenge of extremism—lest step by step, the foundations of law are eroded to the detriment of all of us."

During these trying times it is well for all segments of our society to keep in mind:

"Violence Begets Violence" and *"A House Divided Against Itself Cannot Stand."*

SURGICAL MANAGEMENT OF DIVERTICULITIS

In a recent article* on the surgical management of diverticulitis, Dr. Bentley P. Colcock, of the Lahey Clinic, Boston, stated that no abdominal condition has presented him with a more difficult problem than the complications of this disease. The inflammatory complications are the particular challenge to a surgeon. As the average age of the population increases diverticulitis is seen more frequently, and since the average age has increased 50 per cent since the turn of the century it has become a very common problem.

The author first points out that diverticulitis presents a diagnostic challenge. Many patients with this condition have been operated upon because they were thought to have acute appendicitis. The history, proctoscopic examination and roentgenologic studies should differentiate ulcerative colitis and granulomatous ileocolitis. The most difficult problem is to exclude carcinoma, and Dr. Colcock emphasizes that a diagnosis of diverticulitis should never be made until this possibility is thoroughly studied. In the experience at the Lahey Clinic roentgenologic examination of the colon will not exclude carcinoma in 20 per cent of patients with diverticulitis. A careful history is helpful in differentiating the two conditions. Massive hemorrhage was three times as frequent in patients with carcinoma as in patients with diverticulitis. The reverse was true for pain, particularly colic. The duration of symptoms before operation in diverticulitis was usually more than a year. In patients with carcinoma, symptoms were seldom present for more than six or seven months.

The complication of bleeding presents a problem in both diagnosis and treatment. According to the author, if bleeding is mild and frequent, perhaps several times a week, it is suggestive of carcinoma. Bleeding from diverticulitis is less common, but it may be severe enough to jeopardize the life of the patient. Confusing is the fact that it may occur in patients who have never had clinical symptoms of diverticulitis. In most cases the bleeding will stop and conservative measures can be carried out. However, if the bleeding continues the patient must be operated on to prevent a fatal hemorrhage.

The free perforation of a diverticulum is a true surgical emergency, comparable to that of a gunshot wound of the colon except that the perforation cannot be sutured safely. If the perforation is high enough exteriorization is the procedure of choice, and intestinal continuity can be restored at a later date. If the perforation is in the lower sigmoid and it cannot be brought to the level of the skin without tension, the segment of colon with the perforation is removed, the proximal bowel is exteriorized, and the lower segment is closed. The later restoration of continuity is a difficult procedure but it can be performed. Fortunately, free perforation with an open hole in the colon is rare.

When perforation occurs the inflammatory process surrounding the area of the diverticulum has usually been present for a considerable period of time and instead of a generalized peritonitis developing, an abscess results. Dr. Colcock states that these patients can be treated in one of three ways. First, conservative

* Colcock, B. P.: Surgical management of diverticulitis. J. FLA. MED. ASSN., 57:28-31, 1970.

management may be tried in those patients in whom the physical findings suggest that the abscess is walled off. Bed rest, intravenous fluids and antibiotics often result in an improvement in the patient's condition. When the inflammatory process has completely subsided a decision can be made as to the advisability of a primary resection. Second, if the patient has had several previous attacks, a primary resection may be carried out. If the inflammatory process is not extensive, resection with primary anastomosis can be performed with little risk. It is emphasized that if the anastomosis is made with uninflamed bowel, it should heal without trouble. Third, if the abscess is large and the patient is elderly or obese, a transverse colostomy with or without drainage of the abscess is done to divert the fecal stream. This, of course, necessitates one or two additional operative procedures, but this is the safest course to pursue under these conditions and most of the patients will recover. The author points out that it is in this type of patient that serious and at times fatal complications have developed following a primary resection.

Caution is expressed concerning patients in whom there is a dilatation of the proximal colon. If it is not greatly distended and has been thoroughly emptied preoperatively, primary resection can usually be performed safely, however this decision is based upon surgical judgement. When the colon is greatly dilated, it cannot be safely sutured, and there is no doubt that transverse colostomy is the procedure of choice, for postoperative complications are almost inevitable if a primary resection is done.

Dr. Colcock asserts that there has been an increase in the frequency of postoperative abscesses in recent years, usually following primary resection and due to a leak at the suture line. He emphasizes that these patients need prompt incision and drainage of the contaminated area and a diverting transverse colostomy. Whereas, in patients with a spontaneous perforation of the colon a transverse colostomy leads to a complete resolution of the inflammatory process, this is seldom the outcome when the abscess follows a sigmoid resection. The purulent draining sinus may continue for a year or longer with no evidence of improvement. When it becomes obvious that the inflammatory process is not going to subside, the surgeon must attack it directly. This presents a formidable problem for the tissues are infected and indurated.

The interval that should elapse between diverting colostomy and resection of the sigmoid depends upon the extent of the initial inflammatory process. If it is well localized it may be carried out in two or three months. If the abscess is large or if there is extensive inflammation of the descending colon, if may require six months or a year before the inflammation has completely subsided. The interval between resection and closure of the colostomy stoma is determined by the condition found at the time of resection. The author prefers to send patients home and have them return in six weeks for closure, however if no acute inflammation remains closure can be done at the time of resection of the sigmoid.

It is emphasized that there has been a high degree of morbidity associated with the surgical management of diverticulitis. The author makes recommendations which in his experience reduce the morbidity. He first urges the elimination of operative procedures which have been unsatisfactory in the treatment of complications, such as incision and drainage of an abscess without a proximal colostomy. In the majority of patients this will simply lead to a colocutaneous fistula, and a colostomy will have to be performed before the fistulous area can be resected. A second common error is suturing the performation or the site of a fistula, for a leak with the formation of another abscess is almost certain to occur, and this will necessitate further surgery. Another mistake is the closure of a colostomy stoma without resection. This is a great temptation for after a colostomy the inflammatory process subsides and the patient feels perfectly well. Even the barium enema may appear to be perfectly normal. Sadly, if this course is followed another complication will develop in most of these patients and they will return to their previous state.

Dr. Colcock reported that in the 20 years between 1947 and 1967 approximately 300 patients were operated for diverticulitis at the Lahey Clinic. Of these, 61 had a primary one-stage resection with restoration of intestinal continuity. In the entire group of 300 patients, the mortality was 2.3 per cent, but in those having a primary resection it was 1.6 per cent. A careful review of the operative procedure in

Editorials continued...

the seven patients who died suggested that at least two of them might have survived if a three-stage procedure had been carried out. Significant was the finding that in 57 patients who did undergo the three-stage procedure there were no deaths, despite the fact that these were the oldest patients, poorest risks, and they had the most serious complications.

The Boston surgeon urges earlier surgery for the patient who has persistent or recurrent attacks of diverticulitis, before complications develop. He states, "even one attack when it is associated with an abscess and an illness of two weeks or more is reason enough to consider an elective resection when the inflammatory process has subsided." He concludes with the statement, "in experienced hands and with good judgment in the choice of operative procedure, the mortality rate for the treatment of diverticulitis should be less than two per cent."

WHAT IS AIR POLLUTION?

The topic of air pollution comes up almost daily in our newspapers. Perhaps such submission of publicity is good, because in the past we have given so little attention to the air which surrounds our earth. However, as of this writing, the term *air pollution* is a bugaboo term like *spooks* or *ghosts*. Everyone is afraid of air pollution but few have more than a vague concept of its identity. As a matter of fact, even the "authorities" have only a few general concepts of the problem. Our air contains several hundred or several thousand different types of pollutants. Some single pollutants may be additive to, or negate other pollutants, so that the subject of air pollution is indescribably complex. In order to simplify the problem a little it might be well to describe some of the better known types of pollutants and their effects.

The first type of pollutant is sulphur, producing the so-called "London-type smog." The burning of coal or oil produces a rather stable soot and ash. It also produces sulphur dioxide. Sulphur dioxide when combined with water produces multiple oxides and acids of sulphur which are harmful to vegetation and to the upper respiratory tract of man.

The "Los Angeles photo-chemical smog" is much more complex. This type of smog is largely the result of the combustion of gasoline, and this produces a vast array of poisonous materials. One is nitrogen dioxide which, in turn, may be transformed into other oxides and nitric acid. The Los Angeles type of smog produces about 330 tons of nitrogenous oxides per day. It also produces aldehydes such as acrolein and formaldehyde, both of which are very irritating. Nitrogen dioxide also is affected by heat and releases oxygen in the form of ozone. Ozone is a colorless extremely irritating and destructive oxygen molecule identified by its pungent odor. It reaches deeper into the lungs than sulphur dioxide and produces thickening of the alveoli in laboratory animals. It may be in large part the causative agent which produces photochemical irritation to the eyes and upper respiratory tract.

Carbon monoxide, of course, is produced by the combustion of any number of materials including fossilized fuels and may kill people when it reaches large concentrations in an enclosed space. About 85 per cent of the total of carbon monoxide in the air in our cities comes from automobile exhausts in a concentration of 20 parts per million blocks 3 per cent of our hemoglobin. Strangely enough, however, carbon monoxide seems not to be accumulating on a global basis. It appears to have reached an equilibrium of less than 1 part per million in the general atmosphere. Authorities are not in agreement as to why this equilibrium has occurred in spite of the huge increase in production of carbon monoxide, but it may be that certain bacteria are able to metabolize carbon monoxide to other less noxious compounds.

Benzopyrene is, of course, a substance of prime importance in producing cancer in man and animals. It is a normal constituent of coal-tar and is produced by the distillation or burning of fuel. A-pack-a-day smoker may inhale about 60 micrograms a year from cigarettes.

A non-smoker from Detroit will inhale 80 micrograms, in Birmingham he will inhale 150 micrograms, and in London 320 micrograms or the equivalent of 5 packages of cigarettes a day! Significantly, the death rate for lung cancer for British men is twice the rate for American males. Gasoline exhaust from an idling automobile releases 235 micrograms of Benzopyrene during each minute of operation.

It is to be expected that certain combinations of pollutants will occur. For example, Fluranthene, a non-carcinogenic substance, reaches very high concentrations in gasoline exhausts and heightens the cancer causing effect of Benzopyrene. At the same time, dibenzanthracene, a potent carcinogen in itself, actually seems to inhibit the effect of Benzopyrene on man.

A fascinating experiment by scientists at the University of Southern California first produced a relationship between polluted air and squamous cancer of the lung in mice. Mice and rats seem to be extremely resistant to lung cancer, whereas there are at least 40,000 deaths annually from lung cancer in man in the United States. The researchers at the University of Southern California took 200 highly cancer resistant mice and infected them with the influenza virus. After recovery from the virus 100 of these mice were exposed to ozonized gasoline fumes and the other 100 were given pure air. At length the mice were sacrificed. Eight per cent of the mice exposed to pure air after a bout of influenza had cellular changes in their lungs of a type which often precedes lung cancer. Thirty per cent of the mice exposed to ozonized gasoline fumes had authentic human type cancer of the respiratory tract.

Other complications of air pollution arise from "temperature inversions" and the flow of air about our planet. Usually the temperature near the surface of the earth is warm, while at higher altitudes it is colder. At times, however, the reverse occurs in places like London, Los Angeles, along the East Coast or in river valleys. In such areas warmer temperature often overlies a colder mass near the earth surface and acts as a lid to prevent escape of noxious substances into the air. Such temperature inversions cause enormous increases in pollutants in the air we breathe. Higher up, in the stratosphere, air seems to flow in an area parallel to the earth's surface and becomes trapped there, so that contrails produced by large jet planes and water crystals may float around in the stratosphere for long periods of time and act as a barrier to the sun's rays in penetrating the earth's surface. Such stratospheric effect of the large jets, plus the effect of the temperature inversions may in time affect the temperature of the whole earth's surface. Some scientists feel the earth will warm up because of a "greenhouse effect." Others feel it will cool down due to the inability of the infra-red rays of the sun to penetrate to the earth's surface.

At any rate man is doing a great deal to his environment in the air and it is about time that he begins to be aware of what he is doing. We need to study what the effects of our pollution may have on the future of life on this planet. As of this writing we are just in our infancy in understanding this problem and we are spending very little effort to increase our understanding. It would seem that one of our greater priorities should be to learn more about the effects of pollution of the air so that future generations can live in relative comfort. It seems we should at least give it higher priority than spending by the Pentagon.

DANIEL A. GLOMSET, M.D.

PERFORATION OF INFANT RECTUM

In a letter to the editor in the October 11, 1969 issue of THE LANCET, Smiddy and Benson of the General Infirmary, Leeds, England, report a case of perforation of the rectum by a clinical thermometer. According to the report a nurse attempted to take the rectal temperature of a normal newborn male infant one hour after birth. She encountered difficulty in introducing the thermometer and asked for the help of the house-physician. The doctor inserted the thermometer, noted that it went in for about an inch and then there was a "giving sensation as if a membrane had perforated." During the next 24 hours the infant's abdomen became increasingly distended and he vomited green fluid. X-rays revealed pneumoperitoneum. The

Editorials continued...

baby's condition deteriorated and 24 hours after delivery a laparotomy was performed.

Exploration of the abdomen revealed peritonitis due to meconium and a longitudinal perforation 1.5 cm. in length in the anterior wall of the rectum, commencing at the peritoneal floor. The perforation was closed and meconium was sponged out of the abdomen and a colostomy was performed. The immediate postoperative course was critical but the baby's condition slowly improved and the colostomy was opened on the third postoperative day. Closure of the colostomy was done two weeks after the operation, and the child was discharged from the hospital a month after the initial surgery, apparently entirely recovered.

The authors comment that a rectal thermometer is intended for the sole purpose of determining a baby's temperature. It should never be used as a probe or a dilator, or for other diagnostic procedures. A careful inspection of the anus and a rectal examination with the finger is the safest and simplest method of diagnosing any rectal abnormalities in a newborn infant. It is emphasized that taking the rectal temperature of a neonate must be looked upon as a potentially dangerous practice, and it is questionable whether there is any necessity for routinely taking the rectal temperature of an otherwise normal baby.

In the February 12 issue of THE LANCET, Dr. Edward B. Shaw, a prominent pediatrician of San Francisco, in a letter to the editor, makes the following comment concerning the above case report:

". . . the dismal accident reported by Mr. Smiddy and Mr. Benson must have occurred with the infant recumbent . . . which position, for some reason or other, seems to be preferred by nurses and mothers. If the well lubricated thermometer is inserted with the infant lying prone, this accident is completely preventable; if only the very slight force necessary and permissible is employed, the thermometer practically drops in. In this position the infant is easier to restrain and insertion is not done blindly, fumbling for the orifice and the direction of insertion."

It would appear that the precautionary measure suggested by Dr. Shaw should be impressed upon nurses and mothers, and should be practiced universally in our hospital nurseries and children's wards.

PROBLEMS OF OBESITY

An editorial in the January 19 issue of JAMA (Obesity: A Continuing Problem) declares that obesity is a major health problem in America today. One paragraph in particular deserves the attention of physicians confronted by patients with this frustrating problem, especially when the patient is an adolescent. Growing up is difficult at best, and when it is complicated by obesity the youngster trying to cope with such a challenge needs and deserves unusual understanding and guidance.

The editorial reports that various studies have shown obese individuals respond to their environment in a manner quite different from people of normal weight. Fat individuals are frequently hostile, frustrated and deeply depressed. The fat adolescent is often uncommunicative and withdrawn; the theory of being "fat and happy" is contrary to his true emotional state.

In the management of the obese adolescent weight loss is usually looked upon as a panacea which will resolve their psychosocial and vocational problems. However, emphasis on weight loss tends to increase the feelings of frustration and hostility. Numerous studies have made it clear that weight loss should not be the sole end point for therapy, but rather greater attention should be given to the underlying emotional problems.

Parents should be admonished that too great an emphasis on weight loss can intensify the problem. The fat child needs love and understanding and efforts should be exerted to help him attain self-esteem. Psychologic consultation may prove extremely helpful. Not to be overlooked are the preventive efforts which can be made before the child reaches puberty when emotional problems usually intensify. It is well too to point out that an example of restraint on the part of parents is never amiss.

INFORMATION FROM THE
IOWA HEART ASSOCIATION

Tetralogy of Fallot

JAMES. R. MALM, M.D.
New York, New York

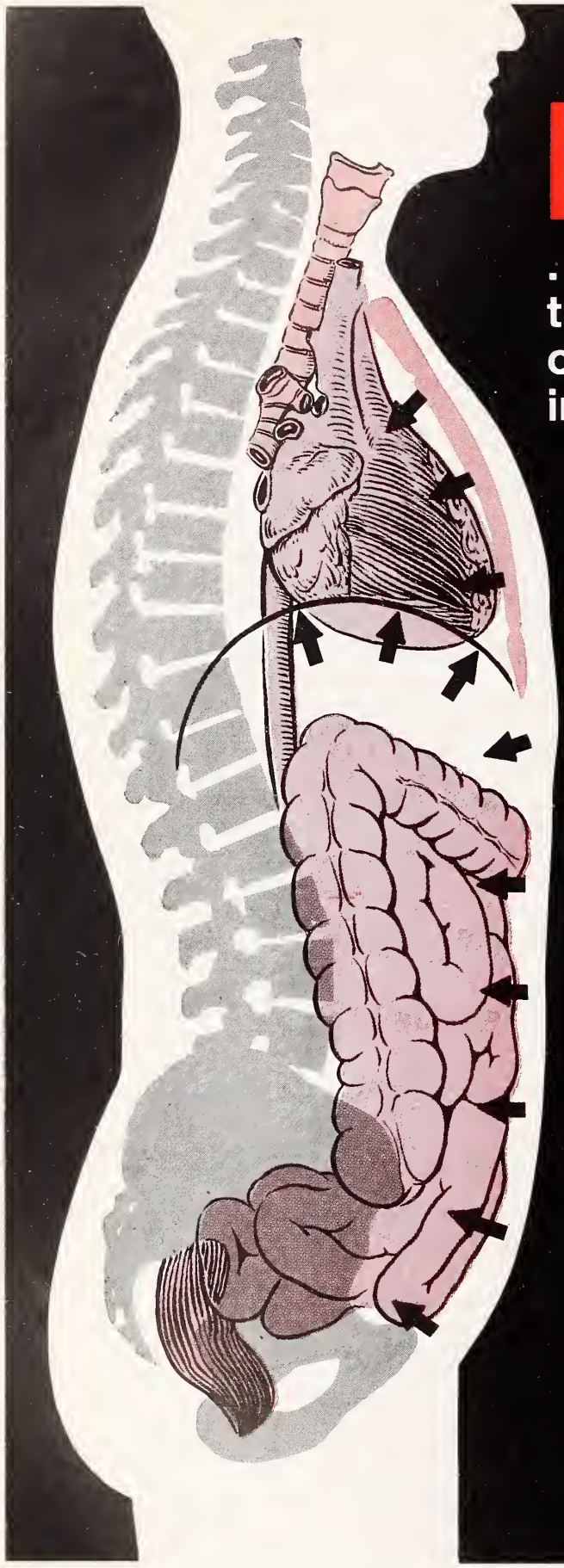
TETRALOGY OF FALLOT is a totally correctible cardiac anomaly, accounting for 30 per cent of all infants with cyanotic heart disease and previously associated with a 25 per cent mortality in the first year of life. While the original anatomic description of this defect included dextroposition of the aorta and right ventricular hypertrophy, these are secondary to the basic abnormalities, namely a large ventricular septal defect and severe outflow tract obstruction from the right ventricle. The hemodynamic result is shunting of systemic venous blood across the septal defect to the left ventricle resulting in peripheral cyanosis and reduced pulmonary blood flow. The degree of outflow obstruction is dynamic, varying with the infant's level of activity or excitement; thus the level of cyanosis may, from moment to moment, change markedly.

The recognition of cyanosis in an infant is an indication for complete diagnostic studies including cardiac catheterization and angiography. Catheterization at this age is safe and establishes an anatomic diagnosis, providing clear guidelines for future management. Life-threatening syncopal episodes, secondary to cerebral hypoxia, or other signs of severe reduction in pulmonary blood flow are an indication for a palliative systemic to pulmonary artery shunt. The recent use of the right pulmonary artery to ascending aorta anastomosis has provided excellent increased pulmonary blood flow, although it is associated with a significant mortality in infants below six months of age. Cyanosis, exertional dyspnea and squatting may not appear until the child's demands for oxygen increase with the onset of walking. A shunting procedure is recommended for symptomatic toddlers and children under four years of age to relieve symptoms, allowing normal growth and development until an age is reached when total correction can be carried out with a low mortality. We recommend carrying out total correction on any symptomatic child over the age of four years, irrespective of the presence or absence of the previous shunting operation. Elective total correction of the anomaly is indicated in the relatively asymptomatic child between the ages of seven and 10 years. The effectiveness of the palliative shunts decreases in 60 per cent of patients as the oxygen demands increase with age, and 7 per cent develop endocarditis at the site of the surgically created ductus. All patients with functioning shunts should be re-evaluated for total correction prior to age 15 years.

Total correction of this anomaly requires closure of the ventricular septal defect, relief of the outflow tract obstruction of the right ventricle and ligation of any existing previously constructed shunt. The correction can be carried out with a mortality of less than 10 per cent and the post-operative course is directly affected by the completeness of the surgical repair. When a complete repair has been carried out the post-operative course is benign, without evidence of cardiac failure or pulmonary complications. Complete correction is sometimes limited by the presence of multiple small septal defects or an extreme degree of narrowing, even hypoplasia, of the outflow tract of the right ventricle. When the outflow tract is markedly narrowed, an outflow tract patch or gusset is required to increase the size of the pulmonary annulus. This patch results in pulmonary valvular insufficiency and is usually associated with moderate to severe degrees of right heart failure during the first two to three weeks post-operatively. These patients require digitalization for two to three months, but have manifested no cardiac limitations in long term follow-up. An extreme form of the anomaly may exist with complete absence of the pulmonary artery. This type of defect can now be repaired utilizing a preserved human aortic homograft as a conduit between the the right ventricular outflow tract and main pulmonary artery. This provides a graft with aortic valves functioning at the pulmonary valve level, avoiding a marked degree of pulmonary valvular insufficiency. These grafts have improved immediate post-operative management.

The late post-operative results have been dramatic. Corrected patients have normal exercise tolerance and no evidence of cyanosis. In our own series post-operative catheterization data suggests that over 90 per cent of the patients have normal or near-normal post-operative hemodynamics. In addition, late hemodynamic studies with exercise demonstrate that these patients have a normal response in cardiac output to exercise. We feel that these post-operative studies and the maintenance of excellent hemodynamics in a follow-up period suggest that long-term outlook is excellent for these patients.

Dr. Malm is a professor of clinical surgery, Columbia University, New York, N. Y.



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Constipation in the chronic heart failure patient carries with it the ever-present threat of acute cardiac decompensation while straining at stool. In the already weakened, distended heart, a sudden influx of blood on termination of the Valsalva maneuver is considered to be the mechanism of some of the deaths occurring in these cardiac patients during straining efforts.*



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Dosage: Adults and children over 12—one or two capsules daily. Children 6 to 12—one capsule daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

*Best, C. H. and Taylor, N. B.: *The Physiological Basis of Medical Practice*, 7th edition, Williams and Wilkins, Baltimore, 1961, p. 480.

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Iowa Association of Medical Assistants

President's Address

To accept the presidency of AAMA, State of Iowa, this particular year is indeed an honor and a responsibility. The year 1970 will see the culmination of several years of planning and many hours of work when the Fourteenth Annual Meeting of the American Association of Medical Assistants is held in Des Moines in October. Iowa is a well educated, proud and resourceful state, and its medical assistants help to maintain this image.

Our 1970 state convention theme—"Yesterday, Today, Tomorrow"—lends itself to a few moments of reflection on where we, as medical assistants have been, where we stand now and what lies ahead.

YESTERDAY was the time when we were preparing for and choosing careers as medical assistants, when we chose and were chosen by our respective physician-employers, because our own particular skills matched their needs for assistance.

YESTERDAY was 1954 when Iowa medical assistants first gave thought to organizing, and 1955 when the Iowa Association of Medical Assistants was formed—and 1955 and 1956 when Iowa girls participated in the first planning sessions to consider a national organization. It was 1957 when the first annual meeting of the American Association of Medical Assistants was held and Iowa medical assistants were present and took an active part.

And YESTERDAY was 1965 when Iowa bid to be the site of the 1970 AAMA CONVENTION, and its bid was accepted.

TODAY we have, in AAMA, a professional paramedical organization, some 11,000 members strong, representing 47 states. We take great pride in having merited the official commendation of the American Medical Association. We are most fortunate in having the strong and loyal support of the Iowa Medical Society. Our component chapters are strengthened by the support of their respective county medical societies and individual physicians. Our programs for certification of medical assistants have become a reality and the number of Certified Medical Assistants is growing each year. We have an association we can truly be proud of—its objectives benefit us . . . the medical assistants, our employers . . . the physicians, and the patients whom we both serve.

TODAY, as a state association, we face our greatest challenge as we invite medical assistants from across our nation to "Reap a Harvest of Education" in Iowa this fall. You will, no doubt, find yourselves "spread quite thin" this year, wearing many hats, and wondering where you will find the time. Yet, we are afforded a unique opportunity to work together in our Association at all three levels—local, state, and national.

TOMORROW will bring many exciting changes in medicine and in medical assisting. It has been said that by 1975, health care will become the nation's largest industry with more than five and a half million persons working in the field. It is our duty to produce the best possible medical assistants. We must make continued efforts to improve existing programs and institute better and more comprehensive programs. We must constantly strive to be better representatives of our Association. Automation will aid us, free our hands and minds from some tasks, but we need not fear obsolescence for no machine will be programmed with empathy, none with warmth, none with a sense of humor, and none with that most important quality of all—that uniquely human spark—



Colleen A. Proffitt
President, AAMA, State of Iowa

(Please turn to page 416)

STATE DEPARTMENT OF HEALTH

ARNOLD M. REEVE, M.D., M.P.H., COMMISSIONER

Planning for Continuing Care of Patients

Thelma Luther, R.N., Director
Division of Nursing

It is estimated in the average sized Iowa county, there may be at least 100 persons in their homes who could use the rehabilitative services of a public health nurse, yet the public health nurse may be aware of only a small percentage of these people, particularly at the time when her services could be most helpful.

The public health nurse can assist patients in their homes more effectively if she is able to work with them early in their illness or immediately after their discharge from an institution. All too often patients are not referred for home care by physicians or hospital personnel, and the public health nurse learns of them later through neighbors, relatives or welfare agencies. Days and weeks of nursing service may have been lost to the disadvantage of the patient. As an example, an Iowa public health nurse quite incidentally found a post-stroke patient who had been confined to bed for over a year and was considered a hopeless cripple. The public health nurse planned with the patient's physician, and finally, rehabilitative nursing service was provided over a three-year period. Eventually the patient was able to walk and do some of her own house work, but much of four years was lost.

Recently a group of Iowa nurses met to discuss ways in which they could contribute more effectively to patient care. The group included hospital, public health and coordinating nurses. Of major concern was their responsibility to communicate with each other and with physicians so that patients, no matter where they are, receive needed care. One of the principal concerns expressed by the hospital nurses was that they often do not have sufficient warning of a patient's discharge to make adequate preparations for future care. A fairly common occurrence, they said, is for a physician to order unexpectedly at 9:30 a.m., for example, the afternoon discharge of Mrs. Smith, a diabetic. The doctor's orders might say "teach patient to give her own insulin." By 10 a.m. the dietitian has been alerted to the patient's discharge and, even though this is her busiest time of day, she hurries to give Mrs. Smith some dietary instructions. Mrs. Smith may not grasp the details of the diet, but there is no time to work with her. At 11:30 a.m. a staff nurse has to leave her other work to demonstrate, hurriedly, the preparation of the insulin and to assist the patient in giving her own insulin. The patient is concentrating on going home and often fails to absorb the instructions given her.

The next scene is Mrs. Smith's home. She lives alone. She was given insulin and a syringe, but she could not read the numbers on the syringe too well. She wonders, "Does the insulin need refrigeration? How was it the nurse sterilized the syringe and needles? How will she buy more insulin? What was it the dietitian meant by food exchanges? Can she afford the needed food? Was it really necessary to test her urine?"

Scene three, two weeks later, might well be the hospital, with Mrs. Smith again a patient.

Now supposing preparations for Mrs. Smith's hospital discharge had started a week earlier. Slides on care of the diabetic could have been shown to her. The dietitian could have spent time helping her understand her dietary needs. Self-insulin administration could have been demonstrated and supervised more thoroughly. The public health nurse could have been alerted and she, by visiting the home, could have discovered that assistance was needed in acquiring supplies and food. The nurse could have arranged her schedule to visit Mrs. Smith the first day she was home.

Public health nurses have a responsibility to share information with hospital and nursing home nurses when patients to whom they have given service are admitted to these institutions. Information about family situations and attitudes is helpful and facilitates nursing care.

Referrals come to public health nurses from many sources: from physicians, welfare workers, neighbors, relatives or the patient himself. If the referral is from other than a physician, the public health nurse contacts the patient's physician for orders. If the referral is initiated by the hospital nurse, physician's orders may already have been secured.

Several hospitals and visiting nurse associations in Iowa are currently employing coordinating

nurses. These nurses, usually with public health nursing preparation, acquaint hospital nurses with community facilities for patient care, stimulate referrals to public health nursing agencies, often secure physician's orders for home care and may visit the patient in the hospital to ascertain home nursing needs.

Written nurse-to-nurse referrals are used by many agencies and these contain identifying patient information, physician's name, description of patient's condition (including physical symptoms, mental attitude, self-care ability) and home and family situation. These may be initiated by a hospital nurse and sent to a public health nurse or initiated by a public health nurse and sent to hospital nurses when the patient is to be institutionalized.

A three-year evaluation* of a home nursing care of the sick project conducted in the Topeka-Shawnee County Health Department, Topeka, Kansas, established the following advantages of home care. The following conclusions or benefits were reported in questionnaires prepared by physicians, families and nurses in the project area.

FOR PATIENTS:

1. Increased comfort.
2. Helped prevent contractures and/or contributed to prevention of greater disability.
3. Helped maintain patients' independence, both by helping the patient help himself and by permitting many of the patients to stay for a longer period in their own homes.
4. Regularity of nursing visits provided some patients with emotional security which they needed.
5. Relieved disabled patients of difficult problems of transportation to the physician's office.
6. Provided more extensive care than otherwise would have been possible.
7. Helped reduce the cost of care.
8. It was reassuring for patients to know that someone was available to visit if help was needed again.

FOR THE FAMILY:

1. Provided services that the family was unable to give.
2. Relieved some of the physical burden of nursing care.
3. Provided the emotional support and reassurance that many families need.
4. In terminal illness cases, family was better prepared for death of relative.
5. Reduced the financial burden of hospitalization and/or nursing care, which would have been necessary without service.

FOR THE PHYSICIAN:

1. Supported physician-family relationship, and thus, also enhanced the emotional support the family needed.
2. Made significant observations, which facilitated medical management.
3. There may have been some reduction in the number of telephone calls and/or medical house calls needed by the patient.

FOR THE COMMUNITY:

1. A large number of the patients were living on small pensions, and without nursing service, they would have required public assistance for other kinds of care.
2. There may have been a slight relief in hospital utilization, primarily by a lessened demand on hospital beds which resulted from deferment or prevention of hospitalization.
3. Community education in nursing care of the sick was extended, at least for families under the program.

It is of interest that of the 290 patients included in the above study, physicians were the chief source of referrals.

Most people agree that planning for continuing patient care is important. Often times it is just a matter of busy people taking time to communicate with other disciplines in their own field, frequently it is a matter of writing or telephoning another agency. In the long run, it saves time for physicians and nurses, and certainly pays dividends in better care for patients.

* Evaluation of the Home Nursing Care of the Sick Project (March 1, 1962-March 1, 1965), Topeka-Shawnee County Health Department, Division of Public Health Nursing, Topeka, Kansas, 1965.

Immunizations for Travel to Expo '70

There may be Iowans who are planning to travel to Expo '70. For ease in securing proper immunization, this brief recommendation for immunization preparation is provided.

For direct travel to Japan and return to the United States, vaccination against smallpox within three years is the only immunization requirement. This must be documented by a properly executed and authenticated "International Certificates of Vaccination" form. No other immunization is indicated if the traveler is going only to Japan. The Department has, for a considerable period, recommended that travelers, as well as residents of Iowa, be immunized against tetanus. The risk is no greater in Japan than it is in Iowa, and the Department considers that immunization against this preventable disease should be maintained effective at all times everywhere.

Persons visiting other Asian countries need an immunization against cholera if they visit an area in which cholera is occurring. Countries presently having infected areas include Brunei, Burma, In-

dia, Indonesia, Malaysia, Nepal, East Pakistan, Philippines, and Viet Nam. Cholera immunization must also be documented on an "International Certificates of Vaccination" form. If the itinerary includes Australia, that country requires a Cholera Certificate of arrivals from Korea and Thailand, in addition to those already listed.

Individuals traveling elsewhere in Asia should have received at some time a full course of immunizations against poliomyelitis, either with inactivated or oral (live) vaccine. A booster dose of trivalent oral vaccine is suggested, but such reinforcement is needed only once and need not be repeated if received for a previous trip. Vaccination against typhoid fever and immune serum globulin prophylaxis of infectious hepatitis are also suggested. The former (typhoid vaccine) should be received several weeks prior to departure for maximal effect, and the latter (ISG) within one to two weeks of departure. Chloroquine prophylaxis of malaria is suggested for Burma, Cambodia, Indonesia, Laos, Malaysia, New Caledonia, the New Hebrides, Papua-New Guinea, Philippines, Thailand and Viet Nam.

Morbidity Report for Month of April, 1970

Diseases	April 1970	1970 to Date	1969 to Date	Most April Cases Reported From These Counties
Brucellosis	5	10	4	Dubuque
Chickenpox	744	3,361	2,735	Black Hawk, Des Moines, Jasper, Linn
German measles	541	1,512	1,517	Butler, Cass
Gonorrhea	429	1,624	1,280	Scattered
Histoplasmosis	3	6	7	Hardin
Impetigo	47	227	171	Polk, Wright
Infectious hepatitis	45	129	156	Pottawattamie, Scott
Infectious mononucleosis	64	278	273	Linn, Polk
Measles	25	73	231	Polk
Meningitis, cryptococcic	1	2	0	Johnson
meningococcal	3	6	11	Jefferson, Polk, Ringgold
Mumps	492	1,788	3,158	Black Hawk, Wapello
Pneumonia	81	345	185	Pottawattamie, Scott
Rabies in Animals	9	30	32	Scattered
Rheumatic fever	9	22	21	Bremer, Scott
Salmonellosis				
S. heidelberg	1	1	0	Hancock
S. infantis	1	3	1	Black Hawk
S. orion	3	4	0	Story
S. paratyphi B	2	2	0	Story
S. thompson	1	1	1	Scott
S. typhimurium	4	10	13	Dubuque, Linn, Scott, Story
Group B	1	4	8	Marion
Shigellosis				
S. flexneri	1	1	0	Polk
S. sonnei	6	32	5	Dallas, Polk
Streptococcal infections	893	3,320	2,121	Johnson
Syphilis	46	188	252	Scattered
Tuberculosis, active	18	52	44	Scattered
Whooping cough	6	11	5	Polk

Iowa Association of Medical Assistants

(Continued from page 413)

Enthusiasm! These are the essentials that make us essential. Cultivate them, practice them, cherish them, for they are your keys to personal happiness as well as to professional achievement and satisfaction.

Our immediate TOMORROW is October, when Iowa's highest aspirations become reality in the 1970 AAMA CONVENTION. Providing an encore to last year's Convention in Hawaii is not an easy task, but Iowa eagerly accepts the challenge.

TOMORROW'S promise is bright, as bright as you make it, you individually and you collectively. Without you nothing can be accomplished, but with your combined efforts, no step is too high, no challenge too great and no task too difficult to complete.

Let us go forward together to achieve Success in Seventy!

—COLLEEN A. PROFFITT,
President, AAMA, State of Iowa

Retains IMS Golf Crown

John J. Polich, M.D., Des Moines, successfully defended his Iowa Medical Society golf title during the 1970 Annual Meeting. Dr. Polich shot a 77 and retained the IMS Cup, which has been provided by the Whylie-Farrell Optical Company of Des Moines.

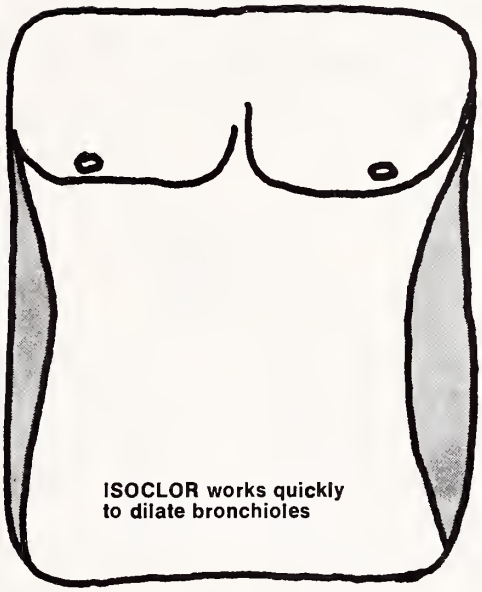
The 1970 tournament runner-up was S. R. Smith, M.D., Red Oak, with a score of 79, and N. M. Johnson, M.D., Clarinda, was third with an 80.

Harold J. McCoy, M.D., the tournament coordinator, has issued an early call for competitors to take part in the 1971 meet. Dr. McCoy would welcome an expression of interest in playing any time during the coming months.

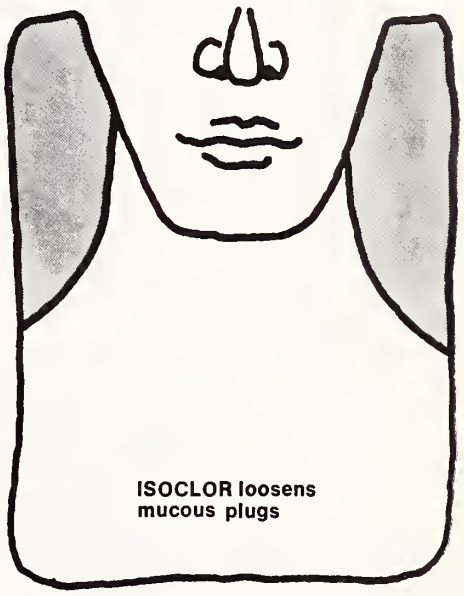
HERE ARE THE COLD FACTS:



ISOCLOR effectively decongests nasal passages



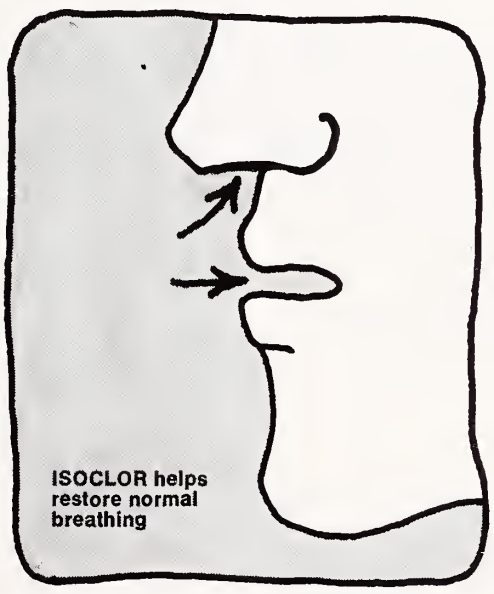
ISOCLOR works quickly to dilate bronchioles



ISOCLOR loosens mucous plugs

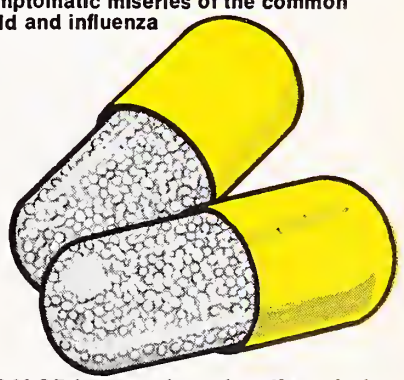


ISOCLOR relieves runny eyes



ISOCLOR helps restore normal breathing

ISOCLOR promptly and effectively combats symptomatic miseries of the common cold and influenza



ISOCLOR helps patients face the cold facts

ISOCLOR®

soclor provides quick, long lasting relief of respiratory congestion and discomfort brought on by common olds, influenza, and allergies. Isoclor contains chlorpheniramine maleate — one of the most potent and afest antihistamines. And pseudoephedrine HCl — a decongestant bronchodilator providing effective and ong lasting relief for the entire respiratory tract. Both work to extend the range of relief.

COMPOSITION: Each tablet or 2 teaspoonfuls of liquid contains:
Chlorpheniramine Maleate 4 mg.
Pseudoephedrine HCl 25 mg.

Each ISOCLOR Timesule contains:

Chlorpheniramine Maleate 10 mg.
Pseudoephedrine HCl 65 mg.
In a special pellet form providing both prompt and sustained effect.

INDICATIONS: For symptomatic relief of colds, hay fever, allergic conjunctivitis, perennial rhinitis of allergic origin and sinusitis. Opens nasal, sinus and bronchial passages orally.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

PRECAUTIONS: Use with caution in patients suffering with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Tablets: Bottles of 100 and 1000. Liquid: 4 oz. bottles, pints, and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

ARNAR-STONE LABORATORIES, INC.
QUALITY—RESEARCH—SERVICE
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Mount Prospect, Illinois 60056

THE DOCTOR'S BUSINESS



Professional Corporation Developments

HOWARD D. BAKER
Waterloo

Following its concession on professional corporations several months ago, I.R.S. recently issued a clarifying statement.

Basically, I.R.S. officials are taking the position that if a corporation is legally established under the specific laws of its state, it will be recognized as a corporation for federal income tax purposes.

I.R.S. will, of course, continue to look at the "business purpose" of the corporation as it has a right to do in the case of any corporation in any location. However, it would appear that discrimination against professional corporations, as such, will be discontinued.

The I.R.S. announcement does not make any specific reference to "one-man" corporations, either by way of exclusion or inclusion.

On March 4, 1970 the Iowa Professional Corporation Act was signed into law. It becomes effective July 1, 1970 and permits one or more persons licensed to practice a profession (or two professions permitted by law to practice jointly) to incorporate.

Included in the list of professions that may incorporate are accountants, architects, chiropractors, dentists, engineers, lawyers, medical doctors, optometrists, osteopaths, podiatrists and veterinarians.

CHANGE IN TAXATION OF WITHDRAWALS

The "Tax Reform Act of 1969" made a significant revision in the taxation of accumulations withdrawn in a lump sum from an employee pension or profit-sharing trust.

Under prior law the total amount withdrawn was taxed as a long-term capital gain subject to a maximum tax rate of 25 per cent of the total gain.

Under the new law, employer contributions made after December 31, 1969 will be taxed as ordinary income with a special seven-year averaging provision. Only those contributions made prior to January 1, 1970, plus the excess of value over employer contributions, will be permitted the capital gain treatment.

Mr. Baker is Manager of the Financial Planning Department for Professional Management Midwest.

For example, a $250,000 distribution is made to an individual. This is represented by $10,000 of contributions prior to January 1, 1970, $140,000 of contributions after December 31, 1969 and $100,000 appreciation. Under old law, the maximum tax on this distribution would have been 25 per cent or $62,500.

Under new law, the $10,000 pre-1970 contributions plus the $100,000 of appreciation will be capital gain with a maximum tax of $27,000. However, the $140,000 of post-1969 employer contributions would be taxed as ordinary income with a special seven-year averaging computation. Assuming a $50,000 taxable income in the year of withdrawal, the maximum tax under the seven-year averaging provision would be $70,000, making a total tax liability of $97,500 under the new law as compared to $62,500 under the old law—an increase of $35,000, a total tax on the $250,000 of 39 per cent instead of the old 25 per cent maximum. However, this tax is still about $28,000 less than the tax would be on the same accumulation under a self-employed retirement plan.

This new provision will not invalidate the professional corporation, but will obviously reduce the tax savings significantly—depending upon the ratio of appreciation to post-1969 contributions.

SUBCHAPTER "S" PROFESSIONAL CORPORATIONS

Beginning with taxable years starting after December 31, 1970, the same contribution limitations that apply to self-employed retirement plans are imposed upon contributions on behalf of stockholders in a subchapter "S" corporation. These limitations are 10 per cent of earned income or $2,500, whichever is lesser. Any contributions in excess of this limitation will be treated as ordinary income to the stockholder.

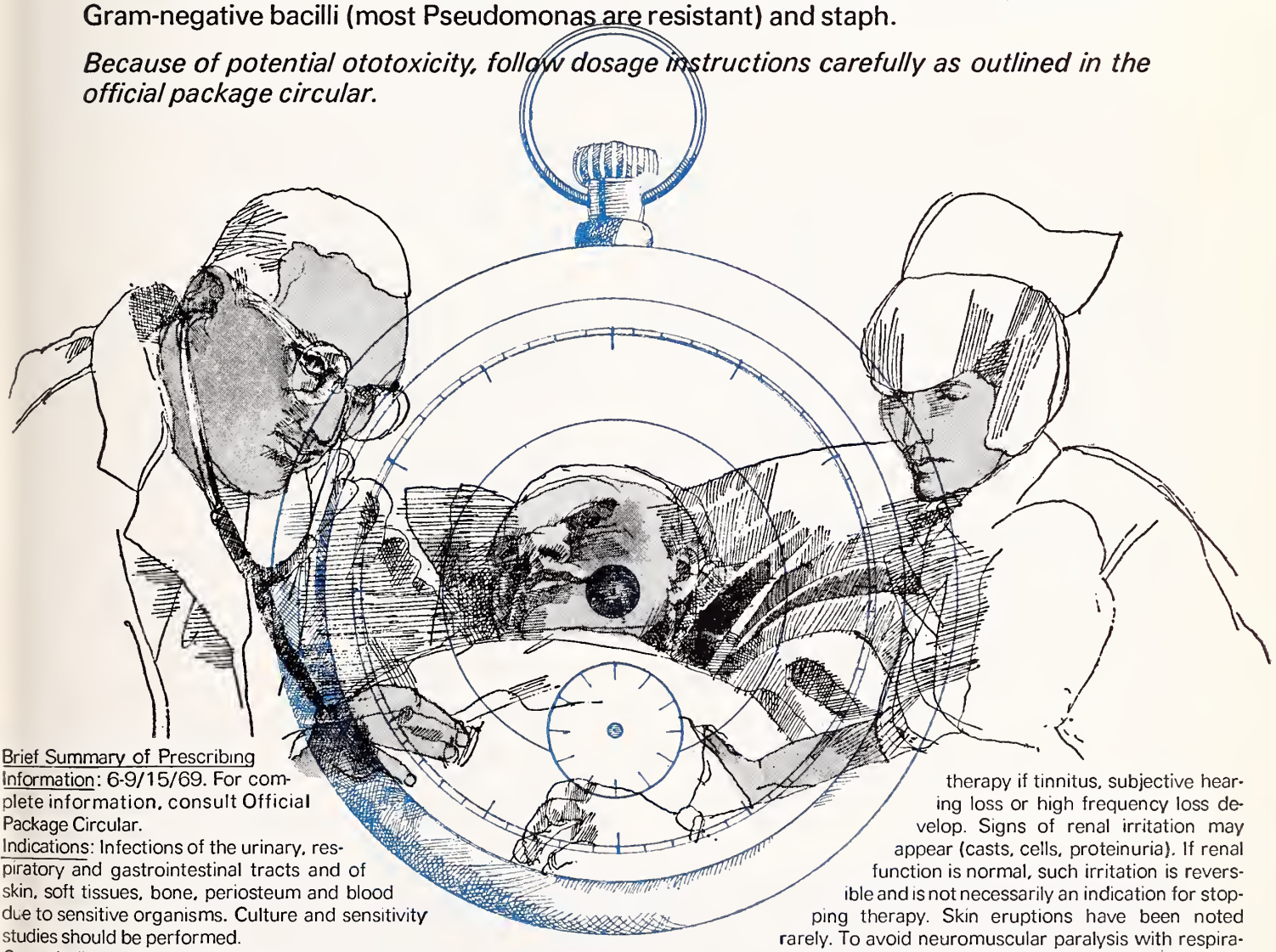
For all practical purposes, and under almost all circumstances, this nullifies the use of subchapter "S" corporations as professional corporations since they will be treated the same as a partnership.

A valuable hospital antibiotic —when there is no time

in severe systemic infections—postoperative bacteremia, Gram-negative/staph pneumonias or neonatal sepsis—Kantrex® (kanamycin sulfate) is often indicated before results of customary sensitivity tests can be reported. Clinical response is often seen within 24-48 hours in susceptible infections, with remission soon after.

10 years of experience confirm the continuing effectiveness of Kantrex® against many Gram-negative bacilli (most Pseudomonas are resistant) and staph.

Because of potential ototoxicity, follow dosage instructions carefully as outlined in the official package circular.



Brief Summary of Prescribing Information: 6-9/15/69. For complete information, consult Official Package Circular.

Indications: Infections of the urinary, respiratory and gastrointestinal tracts and of skin, soft tissues, bone, periosteum and blood due to sensitive organisms. Culture and sensitivity studies should be performed.

Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.

Warnings: Since the drug is excreted almost entirely by glomerular filtration, renal malfunction can cause abnormally high serum levels of kanamycin which may prove ototoxic. Assess renal function periodically, both before and during therapy. Renal dysfunction or pre-renal azotemia sharply increase the risk of ototoxicity and permanent deafness. In such cases decrease the size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. In older patients and patients receiving a total dose in excess of 15 Grams, watch carefully for signs of ototoxicity.

Precautions: If mycotic or bacterial superinfection occurs, discontinue kanamycin and initiate appropriate therapy. Cumulative ototoxic effects may be produced by concurrent or consecutive use of other ototoxic drugs. High doses may cause irritation at injection sites. The drug *should not* be physically mixed with other antimicrobials.

Adverse Reactions: Severe irreversible hearing loss may occur. Stop therapy if tinnitus, subjective hearing loss or high frequency loss develop. Signs of renal irritation may appear (casts, cells, proteinuria). If renal function is normal, such irritation is reversible and is not necessarily an indication for stopping therapy. Skin eruptions have been noted rarely. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxants is complete.

Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gram daily and should not exceed 1.5 Gram even in the heaviest patients. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. 1.0 Gm. in 3 ml.

Also available—Pediatric Injection 75 mg. in 2 ml.

A.H.F.S. Category 8:12.28

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Division of Bristol-Myers Company
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(kanamycin sulfate)

Woman's Auxiliary News

Local and National Activity

State Convention is over with happy memories and new plans for the coming year.

On the local level the most important item of business is sending the names of new officers and committee chairmen to Mrs. Hazel T. Lammey, Iowa Medical Society, 1001 Grand Avenue, West Des Moines 50265. These names are needed for the yearbook and for the national office; their availability will assure officers and committee chairmen of receiving material from their national counterparts.

Next! Please come to Chicago on June 21. Iowans have a great opportunity to attend a National Convention. Pack up the family and head for the AMA and Auxiliary meetings.

There are great things planned for teenagers and pre-teens. Gulliver's Trails will coordinate the activities from Monday, June 22 through Thursday, June 25. Following is the schedule:

Monday—Pre-teens and Teens—Boat Ride and Museum of Science and Industry.

Tuesday—Pre-Teens and Teens—Swim, Sightsee and an Opening Night Theater Party.

Wednesday—Pre-Teens—Brookfield Zoo, Porpoise Show and Newspaper Tour. Teens—Newspaper Tour, University of Chicago.

Thursday—Pre-Teens and Teens—Marina City, The Lincoln Story and The Police Academy.

The Auxiliary program will appeal to you, too. On Sunday the President, Mrs. John M. Chenault, and President-elect, Mrs. R. C. L. Robertson will be honored at a reception at the Drake Hotel (our headquarters) from 5:00 to 7:00 p.m. The keynote address will be given Monday morning by Mrs. Louise Bushnell, Director, Women's Activities, National Association of Manufacturers. Her topic will be "The Challenge to Women in the '70s."

A "Nite on the Town" is planned for Monday evening.

Dr. Dorman, President of the AMA, will be guest speaker for the annual luncheon on Monday.

On Tuesday there will be a colorful and historical pageant of costumes worn by women in different countries of the world. Appropriate slides and music from the various countries will be part of the presentation.

State presidents will give their reports on Monday and Tuesday afternoons and these are fascinating. Jeanne Coughlan will give Iowa's on Monday. Let's support her with a big attendance. "Show and Tell" exhibits developed by state and county auxiliaries will be open at 4:00 p.m. on Monday and 2:30 p.m. on Tuesday.

Please write to me for further details or information and call me during the convention at the Drake Hotel if I may help you in any way. National meetings provide such a broad view of what is happening in the medical field in our 50 states and around the world.

It was a pleasure to welcome many officers and committee chairmen to the post convention board meeting. Elsewhere in this issue you will find the calendar for the year. Mark the dates where you won't forget to look at them and join us whenever possible. Let's continue the "getting-to-know you" idea that Jeanne stressed and widen the circle.

My best wishes for a healthy, happy summer.

—Marion Prewitt

1970-1971 Calendar

1970

June 21-25—National Auxiliary, Chicago
July 13—Executive Committee, Iowa Medical Society Building, Des Moines
September 21—Annual Meeting Committee, Ottumwa
September 22—Board of Directors, Ottumwa
October 11-14—Conference of Presidents and Presidents-elect, Chicago
October 15-16—North Central Regional Workshop, Chicago

1971

January 11—Annual Meeting Committee, Des Moines
January 12—Board of Directors, Des Moines
April 25-28—Annual Meeting, Woman's Auxiliary to the Iowa Medical Society, Des Moines

National President Addresses Auxiliary Annual Meeting

"No doubt you have been dismayed," said Mrs. John M. Chenault of Decatur, Alabama, "by the upsurge in the publicity which is giving the medical profession a distorted image."

So said the President of the Woman's Auxiliary to the AMA in her luncheon remarks in Des Moines on April 28. She declared that the Senate Finance Committee Staff Report (February 9, 1970) was critical of physicians and administrators for their abuse of the Medicare and Medicaid programs. She also called attention to the recent GOOD HOUSEKEEPING article which used half-truths to prove that "you really can't get good medical care." She also referred to the two CBS television programs on health care in the United States.

ANSWER ACCUSATIONS

"When you are presented with a golden opportunity to refute such criticism," said Mrs. Chenault, "you may want to use some of the points made by Dr. Gerald Dorman, President of the AMA." She attributed the following statements to Dr. Dorman: "The medical and health care system of this nation is a good one. It has not broken down. It is not falling apart. It is not riddled with graft, nor festering with incompetence. It is made up of men and women who are proud of their skills and dedicated to using them for the betterment of their fellow man."

She quoted Dr. Dorman further, "The system is, however, understaffed. It is crowded with patients, for whom it is doing the best possible job. It performs miracles now and then. But mostly it just goes along its way, doing a yeoman job of taking care of millions of people who need help.

"The furor comes about—and rightly so—because there are people in our huge nation—in its big cities, in its rural area—whom the system does not reach as often as it should. There are people to whom it is not as easily available as it should be.

"Nobody recognizes those weaknesses more clearly than physicians. And nobody is working harder to eliminate those exceptions to an overall picture of good care for the nation. Along with many other concerned persons, we see a situation that must be changed. It is one that can be changed and we will work together to change."

THE DISTAFF SIDE

Mrs. Chenault posed this question, "As members of the distaff side of American medicine, how can we proceed to make these times good times in which to live?"

She answered her question, "We must recognize and understand changes that are likely to take place, such as in the imbalance of supply and demand and the need to increase the quantity and the accessibility of care and services without sacrificing quality. Innovative solutions must be found for if they are not, they will be handed down to us, like it or not.

"We must make an impact in the community where we live, through auxiliary projects, cooperation with other groups or through individual activity in such a way to catch the interest of and fill needs in the community.

"We must recognize and be responsive to the concerns of the nation. And then we must use our imagination as we assist the medical profession in community health projects.

"Let us not be bashful about letting others know of the work we do and make a habit of showing our best face to the world—a face of concern, commitment and service."



1970-71 AUXILIARY OFFICES—These new officers were installed by Mrs. John M. Chenault, National Auxiliary President, on Tuesday, April 28. Left to right, Mrs. Frederic M. Ashler, Hamburg, Councilor, District XI; Mrs. Joseph F. Veverka, Prairie City, Treasurer; Mrs. Olin A. Elliott, Des Moines, Recording Secretary; Mrs. Philip H. Tenney, Independence, President-elect; Mrs. Leland H. Prewitt, Ottumwa, President; Mrs. Ralph L. Wicks, Boone, First Vice President; Mrs. Stephen G. Weiss, Davenport, Councilor, District VIII; Mrs. Nobel W. Irving, Des Moines, Councilor, District V. Mrs. Milford D. Hayden, Cherokee, Second Vice President, and Mrs. Norman Reitzel, Vinton, Councilor, District VI, were unable to be present.

In Memoriam

After the tempest—calm
After the shadow—light,
And the golden dawn breaks clearly
After the long, long night,
After the rain, the sunshine,
After the tears, the laughter
And when this life is over,
Life eternal follows after.

In Memory of	*County*
Mrs. A. B. Deering Boone	Boone
Mrs. Ben T. Whitaker Boone	Boone
Mrs. L. L. Long Perry	Dallas-Guthrie
Mrs. John McKitterick Burlington	Des Moines
Mrs. R. C. Reimers Fort Madison	Lee (North)
Mrs. Thomas Burcham, Sr. Des Moines	Polk
Mrs. Lawrence W. Porter Indianola	Polk
Mrs. L. J. Dierker Davenport	Scott
Mrs. A. C. Sorenson Bettendorf	Scott
Mrs. D. L. York Creston	Union
Mrs. Robert N. Larimer Sioux City	Woodbury

The Woman's Auxiliary to the Iowa Medical Society honored these deceased members at a memorial service April 28, 1970. Contributions to the Health Education Loan Fund have been made by the Auxiliary in memory of these deceased members. Mrs. Max E. Olsen conducted the memorial service, assisted by Mrs. Keith M. Chapler, at the piano.

HELP!!!

County Presidents PLEASE send the names of (1) your officers for the 1970-71 year and (2) your committee chairmen to the Iowa Medical Society Headquarters Office, 1001 Grand Avenue, West Des Moines 50265. Do it NOW!

Fran Hayden, the yearbook chairman, is still in the hospital as the result of a serious automobile accident, but she is anxious that her assignment as yearbook chairman not be neglected. Will you please help her with the details that must come from your county. Mark your communication to the attention of Hazel T. Lammey and Fran will be kept up to date on the progress of her project.

To Jeanne Coughlan—Thanks a Million!

. . . For a wisely organized, smoothly run convention (for the same kind of meetings through the year); for providing fun as well as work; for solving more problems than were created; for being calm and collected; for making many friends among us; for GIVING and LEAVING with the Auxiliary a part of yourself to build onto those contributions of past presidents.

As you join that select group of women, may we also thank you for inviting to our convention such a fine group of guests, who did so much to make the two days pleasant and informative. And—for pulling off the minor miracle of having time left over on Tuesday morning for the free exchange of ideas.

Maybe it isn't *Thanks a Million,* but surely it is Thank you 1,175 times from the bottom of our collective hearts, for being our President!

—AN EDITORIAL

Quotable Quotes

From Three Distinguished Guests at Annual Meeting

"The most important paramedical personnel of the doctor is the doctor's wife. Wives should see that their husbands don't work too hard; doctors think nothing can happen to them—it can!"

WILLIAM F. KRIGSTEN, M.D.
President, IMS, 1969-70

"The youth are coming up with solutions for community improvement. The government is an auxiliary in solving current problems."

THE HONORABLE ROBERT D. RAY
Governor of Iowa

"Colleges used to be a refuge from the burdens of society. No longer is the Ivory Tower isolated, it is the market place where all the problems of the society are aired; the impulses and impact are so strongly felt that it has become the cockpit of the action. Universities are attempting to understand what is happening and to represent it to the community; but, the obligation is to the MAJORITY of the students.

Many students feel that their college is impersonal, when it is merely complex, and it still considers its basic function that of creating and transmitting knowledge. Problems are going to be solved by technology and its application, NOT through some political magic. Even though there is a diminishing interest of adults in education, the University system will not be overthrown if people—a great many of them—still have faith in it."

DR. PAUL SHARP, *President*
Drake University
from an address
"The Age of Transplant"

Around the Hawkeye State

Dubuque County

The Homebound Sale, a pet project of the Auxiliary, took place in downtown Dubuque three days last October. Proceeds from the sale of items made by the handicapped are returned to the individuals; in some cases this is their only source of income.

The 54 Dubuque auxiliary members hold their regular meetings at the Dubuque Golf and Country Club the second Tuesday of each month.

North Lee County

Mrs. A. C. Richmond, past state president, presided at the meeting of the April 8 Auxiliary at the Carriage Inn in Fort Madison. Eighteen were present, including the following state officers: Mrs. Joseph Kehoe, Davenport, Councilor of District VIII; Mrs. Rollin Perkins, Davenport, AMA-ERF Chairman; Mrs. Leland Prewitt, Ottumwa, President-Elect, and Mrs. Daniel Coughlan, Des Moines, President.

Mrs. Jaime Polit is the new president of the Lee unit, and Mrs. Robert Kent will be the State International Health Activities Chairman next year.

Polk County

Mrs. Edward J. Drew was installed as President of the Woman's Auxiliary and Mrs. Meredith Saunders was chosen president-elect at a May 8 brunch at the home of Mrs. Joseph Song.

Other new officers are Mesdames Robert Foley, First Vice-President; Dennis Wilson, Second Vice-President; Harold Eklund, Recording Secretary; Donald Anderson, Treasurer; Charles Hull, Corresponding Secretary.

Past Presidents were honored.

Scott County

Doctors' wives in Scott have dedicated many hours during the year, as they have in the past, to a myriad of service organizations and health related boards within the community.

Within the organization a warm bond of friendship exists among the active women, and an effort is made each year to greet new medical families with spontaneous interest and cordiality.

In addition to projects already reported, $200 was donated to the local Rubella program. Contributions have been made to WA-SAMA and AMA-ERF. The collection of drugs and Johnny Coats for International Health has continued. A medical booth was manned at the Mississippi Valley Fair and individual members staff a monthly meal service route at St. Lukes Hospital. Mrs. Daniel Coughlan, State President, was welcomed at the November Reciprocity Luncheon for Dental, Farm Bureau and Pharmaceutical Wives, at this George Morrissey gave a light-hearted view of Mercy Hospital's 100 Years of Service.

Wives were guests at the January meeting of Scott Medical Society and enjoyed a program on "Medicine in Russia" given by Dr. Jack Sunderbruch.

The following monthly programs have been arranged by Mrs. Dennis Miller: Downtown Davenport Renewal Project; Sex Education in the Schools; Africa and Missions; Drugs Children are Using; and a Spring Style Show. Officers are to be installed in May.

Wapello County

The Auxiliary met May 5 at the home of Mrs. Lloyd Gugle. Reports of the State Convention were given. Eleven members were present in Des Moines on April 28 when Mrs. Leland Prewitt was installed as State President.

Mrs. Arthur Austin installed the new county auxiliary officers: Mrs. Ralph Moress, President; Mrs. Dennis Emanuel, Vice President; Mrs. Warren DeKraay, Secretary; and Mrs. Dale Emerson, Treasurer.

From Your New Editor

It was just a few days ago that I began. And already I have the deepest respect for the job Margaret Mater (and all the Editors before her) and Hazel Lammey have done to bring this publication to you.

THE NEWS is YOURS. It should represent *your* thoughts, *your* aims, *your* accomplishments. Make it yours by sending to me, by the FIRST OF EACH MONTH, news of your county.

Suggestions about what you would like to read will be welcome. If you have ideas, ideals or peeves to share, we will start a Letters to the Editor column. Your cooperation is needed.

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501

President-Elect—Mrs. P. H. Tenney, 203 Second Avenue, SW, Independence 50644

Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312

Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228

Editor of THE NEWS—Mrs. J. L. Kehoe, 111 McClellan Blvd., Davenport 52803



Personals



Dr. A. D. Smith, of Primghar, was one of four northwest Iowa Boy Scout leaders who received the Silver Beaver Award at the 50th Anniversary Recognition Banquet of the Prairie Gold Area Council, Boy Scouts of America. The banquet was April 14 at the Cobblestone Inn in Storm Lake. The Silver Beaver Award is the highest honor that may be given by a local Boy Scout Council, and requires a minimum of 10 years of service in Scouting plus an outstanding record of service to church, community and other youth-serving organizations or programs.

Dr. Mary Lyons, of Des Moines, participated in a panel discussion on "Children's Emotional Health," at the April PTA meeting of Fair Meadows School in West Des Moines.

Dr. Paul D. Boone, of Paullina, has assumed medical chairmanship for the O'Brien County-Municipal Civil Defense organization. This position was vacated recently by **Dr. Ivan E. Brown,** of Hartley, who had held it since 1962.

Dr. Axel T. J. Lund, of Ackley, was among 41 coaches, trainers, and team physicians who participated in the Fifth Annual Teaching Days in the Prevention and Management of Sports Injuries held recently at the University of Wisconsin in Madison.

Dr. Daniel M. Kelly, of Emmetsburg, discussed the medical, social and economic aspects of drugs at the April meeting of the Palo Alto County Hospital Auxiliary in Emmetsburg.

Dr. Earl G. Rozeboom, of Winterset, has been appointed medical examiner for Madison County.

Dr. Chester McClure, of Independence, a psychiatrist at the Mental Health Institute, spoke recently in Dubuque at the third annual workshop on sex education sponsored by the Westminster Presbyterian Church Family Life Education Committee. His particular topic was the "Psychology of Sex."

The LeMars Clinic recently hosted a dinner meeting at the home of **Dr. Sherman Lindell.** Guests at the dinner were otolaryngologists in LeMars for the crippled children's clinic, as well as physicians from the Plymouth and Sioux County Medical Societies.

About 200 friends of **Dr. E. E. Gingles,** an Onawa physician, gathered recently at the Center Heights Apartments there to celebrate his 75th birthday. Souvenirs and mementos depicting Dr. Gingles' many interests and activities were displayed.

Dr. Donald Van Etten, of Mason City, was the featured speaker at a recent Lions Club meeting in Northwood. Dr. Van Etten spent four years as a medical missionary to Baharine, an island in the Persian Gulf, and he showed slides of the area.

Dr. R. A. Huber, of Charter Oak, was presented the 1970 "Citizen of the Year" award at the annual community dinner in April. Dr. Huber was given a plaque in recognition of his 23 years as a general practitioner there and in appreciation of his active concern for the betterment of the community. Dr. Huber has served on the school board, in the community club, commercial club and Charter Oak Enterprises. He is a staff member at Crawford County Memorial Hospital and at the present time serves on the board of directors of the Iowa Chapter, American Academy of General Practitioners.

Dr. John M. Graether, a Marshalltown ophthalmologist, was recently elected president of the newly formed Marshalltown Area Health Planning Assembly. At its first official meeting, the the group voted to become a part of the Health Planning Council of Central Iowa, and it will be considered for formal affiliation at the next meeting of HPCI. The new Marshalltown Assembly consists of 26 community and medical leaders.

Dr. John N. Kenefick, of Algona, has retired after 39 years of general practice. A graduate of the U. of I. College of Medicine, Dr. Kenefick has delivered in the neighborhood of 2,500 infants; he delivered the only set of triplets born in the area over the last 20 years. When he began his practice in Algona in 1931, Dr. Kenefick assisted his uncle in an office which treated about 20 patients a day. More recently he has seen that many patients in one morning. Dr. Kenefick plans to spend some of his retirement time at his Minnesota cottage on Big Sandy Lake, and he also expects to do some warm salt-water fishing in Florida.

At the annual meeting of the Black Hawk County Tuberculosis and Respiratory Disease Association, **Dr. Robert C. Miller,** of Waterloo, received a special award "for distinguished service in the fight against tuberculosis and other respiratory diseases." Dr. Miller retired from the organization's board after 28 years of service. A new board member elected at the meeting was **Dr. Robert G. Hathaway,** of Waterloo. Among the board members re-elected for three-year terms were two Waterloo physicians, **Dr. Newton A. F. Sampaio** and **Dr. Maurice M. Wicklund.**

Dr. Joseph Whelan, assistant director of the Security Hospital at Oakdale, was guest speaker at the April meeting of the Keokuk County Nurses Association in Sigourney. His topic was "The Approach to Death and the Dying."

Dr. S. P. Leinbach, of Belmond, addressed the 23rd National Conference on Rural Health in Milwaukee, Wisconsin in April. His subject was "A Community Meets a Disaster."

Dr. Robert E. Durnin, professor of pediatrics at the U. of I. College of Medicine, was guest speaker at the spring meeting of the Northwest Division of the Iowa Heart Association in Sioux City. **Dr. F. B. O'Leary,** president of the division, presided at the meeting.

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Dr. Joseph Song, a Des Moines pathologist, presented a paper entitled, "Circulating Cancer Cells," at the Tenth International Cancer Congress held in May at the Sheraton-Lincoln Hotel in Houston, Texas.

Dr. William W. Bonney, associate professor of urology at the U. of I. College of Medicine, spoke at the April meeting of the Wright County Medical Society.

Dr. William R. Wilson, of Iowa City, was installed as president of the Iowa Heart Association at the group's annual meeting in Des Moines May 16-17. Dr. Wilson, head of Clinical Pharmacology at University Hospitals, is a member of the Medical Advisory Board of the Council on Circulation of the American Heart Association. Dr. Wilson has served the Heart Association for many years on a local, regional and national basis.

Dr. James P. Slattery, of Pocahontas, is featured as "A Vanishing American" in a recent issue of the Northern Natural Gas Co. publication, "Transmission." Dr. Slattery is described in the article as a "country doctor, a small town practitioner, one of a vanishing breed of men whose ranks grow smaller with each passing year."

Dr. Harry Harper, Sr., of Fort Madison, recently received two achievement awards from Kappa Alpha Psi, Dr. Harper's college fraternity. The awards were presented in Peoria, Illinois, at the regional meeting of the fraternity's North Central Province. Dr. Harper was presented a trophy for having made the most achievement during the past year among the nominees for the award. He also received a plaque for having contributed more than any other member of the Springfield Alumni chapter of the fraternity since its founding in 1923.

Dr. David Stearns, of Nevada, participated in an April panel discussion on family practice at the University Athletic Club. The program for medical students was sponsored by the Iowa Chapter, American Academy of General Practice.

Dr. T. R. Viner, of Leon, was a guest speaker at a recent workshop on "The Legal Aspect for Nurses." The workshop was sponsored by the Seventh District of the Iowa Nurses Association and was held in Leon April 9.

Dr. John R. Scheibe, of Bloomfield, recently attended the national meeting of Blue Shield Plans of the United States in Bal Harbour, Florida.

Dr. Dohn Kruschwitz will begin practicing medicine in Conrad the first of August in association with **Drs. Glendon Button** and **Robert Patterson.** Dr. Kruschwitz attended McPherson College and is a graduate of the U. of I. College of Medicine. He served his internship and residency at Broadlawns Hospital in Des Moines. For the past two years he has been on the staff of a mission hospital in Castaver Puerto Rico. Dr. Kruschwitz and his family will move to Conrad from Puerto Rico sometime in July.

Dr. Beryl F. Michaelson, of Dakota City, participated in a program on drug abuse at the April meeting of the St. Mary's Ladies Society in Humboldt.

The Boone and Story County Medical Societies were among the co-sponsors of a series of three meetings on diabetes held recently in the Ames Public Library Auditorium. **Dr. Guillremo Suarez,** of Ames, spoke on "New Horizons in Diabetes" at the April 14 meeting.

Dr. John P. Barthel, of Cedar Rapids, spoke on "Drugs in Our Community," at a recent meeting of Delta Delta Delta sorority in Cedar Rapids.

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Dr. Frederic M. Ashler, of Hamburg, flew members of the Fremont County Board of Health to Des Moines recently to attend the Governor's Conference on Health, Pollution and Disposal of County and City Solid Wastes.

Dr. Walter M. Block, a Cedar Rapids pediatrician, spoke recently at a meeting of the Tama County Medical Society held in Marshalltown. Dr. Block showed a film produced by the Ciba Company on the "Hyperkinetic Child," and a discussion followed.

Dr. Robert E. Votteler, of Marshalltown, reported on "Family Relations and the Change of Trends in Our Society," at the May meeting of the Marshalltown Unit of Licensed Practical Nurses.

Dr. Frank S. Larsen, of Fort Dodge, was elected president of the Iowa Clinical Surgical Society at that organization's annual meeting held in Oskaloosa in early May. **Dr. Geoffrey W. Bennett,** of Oskaloosa, was named president-elect.

Dr. John N. Martin, of Clarinda, was principal speaker at the annual meeting of the Page County Tuberculsosis and Health Association. Dr. Martin showed his collection of rare medical books and discussed the history and development of medical practice. Page County physicians elected to office in the association were: **Dr. Kenneth J. Gee,** of Shenandoah, community service, and **Dr. H. S. Frenkel,** of Clarinda, legislative and medical representative.

Dr. Gary P. Hayes, of Eldora, presented a program on drugs at an open meeting in the Eldora School Auditorium on April 29. The program was sponsored by the Eldora Teen Age Republicans in cooperation with the Eldora School.

Dr. Albert Selke, assistant professor of radiology at the U. of I., spoke on "X-Ray Diagnosis of the Abused Child," at the conference on "The Battered Child: Medical, Legal, and Social Management," held recently at the U. of I.

Dr. Campbell F. Watts, a Cedar Rapids physician and surgeon, addressed student nurses at the capping ceremony at St. Luke's Hospital School of Professional Nursing, April 5.

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

A most worthwhile mechanism for creating a memorial to a relative, associate, colleague or friend exists in the Scanlon Medical Foundation/Iowa Medical Society. The Foundation utilizes memorial gifts to carry forward its loan program which has helped more than 300 young Iowans finance their medical educations. The Foundation will be glad to send an appropriate card in the name of the donor to the family of the person honored. The tax-deductible memorial gifts should be directed to the Scanlon Medical Foundation/ Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

An expansion program currently in progress at the McCrary-Rost Clinic in Lake City will nearly double the medical facilities now serving that city and the surrounding community. The completed building will accommodate 10 physicians and provide 26 examining rooms. There are presently eight physicians associated with the clinic—**Drs. Glenn Rost, Ashton McCrary, Paul Ferguson, Dale Christensen, Cesar Cardenas, James Comstock, David McCoy** and **Jean Rickey.**

Dr. Montague S. Lawrence, of Iowa City, has been elected president of the Iowa Thoracic Society. Other officers named at the group's May meeting are **Dr. Craig Ellyson,** of Waterloo, vice president; **Dr. Sergio Rabinovich,** of Iowa City, president-elect, and **Dr. James E. Kelsey,** of Des Moines, secretary-treasurer. Executive committee members are **Dr. George G. Spellman,** of Sioux City, immediate past president; **Dr. Joel Teigland,** of Des Moines; **Dr. Hal B. Richerson,** of Iowa City; **Dr. John S. Chapman,** of Dubuque, and **Dr. Hans S. Frenkel,** of Clarinda. **Dr. George**

N. Bedell, of Iowa City, is representative councilor to the American Thoracic Society.

Dr. Maurice W. Kirlin, of Spirit Lake, was married May 2 to **Audry R. Neustrom** at St. Mary's Rectory in Storm Lake. Dr. Kirlin practices at the Spirit Lake Medical Center.

Dr. Glenn S. Rost, of Lake City, was installed as president of the Iowa Academy of Surgery at the group's annual spring meeting in Des Moines. Dr. Rost succeeds **Dr. Montague Lawrence,** professor of surgery at the U. of I. College of Medicine. He has previously served as secretary, treasurer and vice president of the Academy. Dr. Rost came to Lake City in 1946 and has been associated with the McCrary-Rost Clinic since that time.

Dr. D. E. Wolters, Estherville physician, discussed obesity and its many dangers at a recent meeting of the Estherville TOPS Body Shop. Dr. Wolters answered questions asked by the members at the close of his talk.

A loan fund has been established at the Jackson County Public Hospital through the generosity of **Dr. O. L. Frank,** long-time Maquoketa physician. It is to be known as the "Frank Memorial Student Nurses' Loan Fund" and will provide financial assistance to senior nursing students. To receive a loan, a student must reside in the area serviced by the Jackson County Public Hospital.

Dr. William E. Owen, of St. Ansgar, in an "Open Letter to My Patients," which appeared in the ST. ANSGAR ENTERPRISE, asked the residents of the community to write letters to **Dr. H. J. Nickerson,** a native of St. Ansgar and prospective physician for the community. The letter writing campaign is an attempt to let Dr. Nickerson know his hometown really needs him and is hopeful he will return to St. Ansgar to practice medicine.

Dr. Wm. A. Seidler, of Jamaica, recently attended two medical meetings in Chicago. As Pres-

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ident of the Iowa Chapter of the American Academy of General Practice, Dr. Seidler represented the Iowa general practitioners at the annual meeting of the Illinois Academy of General Practice. Following that meeting, he attended the American Railway Surgeons meeting in his capacity as surgeon for the Milwaukee Railroad.

Dr. Robert M. Bittle, assistant professor of psychiatry at the U. of I. College of Medicine, spoke on "Drugs and Today's Young People," at a recent public meeting held in Clinton.

Dr. Otto N. Glesne, of Fort Dodge, was the keynote speaker at a seminar on drug abuse held in Rockwell City recently.

Two Iowa physicians participated in an April seminar on coronary care for nurses in Harlan. **Dr. J. J. Collignon,** of Council Bluffs, discussed the "Anatomy and Physiology of Myocardial Infarction," and **Dr. H. S. Frenkel,** of Clarinda, reviewed the "Drug Therapy in Acute Myocardial Infarction." The meeting was sponsored by the Southwest Division of the Iowa Heart Association.

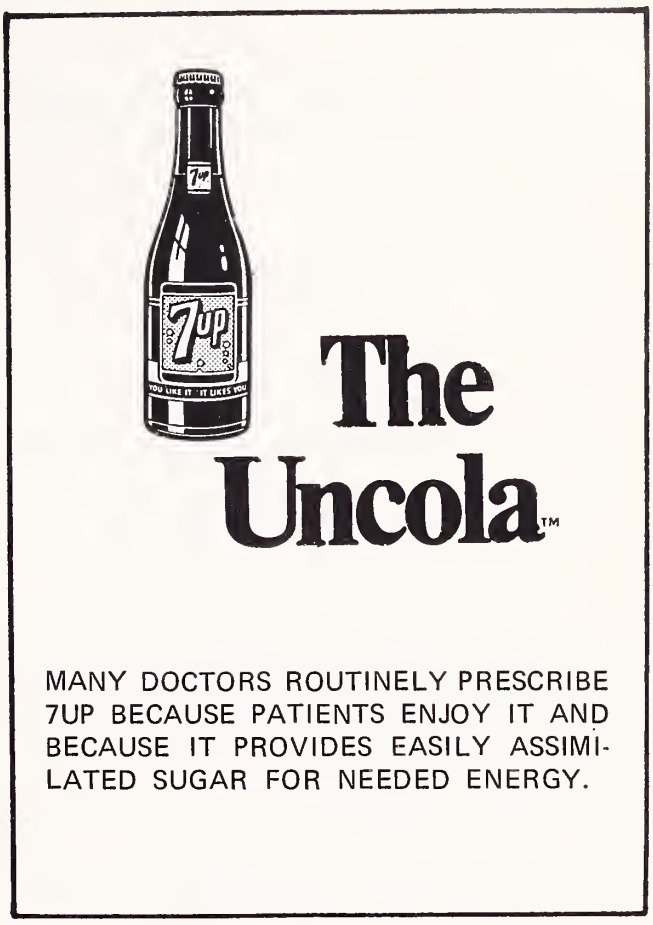
Dr. Terry J. Sutton, now serving in the U. S. Air Force, will join the Medical Arts Clinic in Fairfield in September. Dr. Sutton is a graduate of the Kansas Medical School at Kansas City and served his internship at Mercy and St. Luke's Hospital in Cedar Rapids. He took his surgical residency at Grosse Pointe, Michigan. There are now three physicians associated with the Medical Arts Clinic. They are **Dr. Robert Ryan,** founder of the practice, **Drs. Kirk Strong** and **Gene Egli.**

Deaths

Dr. Robert T. Smith, 70, longtime Granger physician, died at Des Moines Veterans Hospital on Monday, March 31. Dr. Smith attended the University of Iowa and graduated from St. Louis University Medical School in 1924. Following his internship at St. Francis Hospital in LaCrosse, Wisconsin, Dr. Smith entered into practice with his father, the late Dr. Channing G. Smith at Granger in 1925, and served that community for 40 years. He was a member of the American Medical Association, Iowa Medical Society and the American Academy of General Practitioners.

Dr. Albert J. Jongewaard, 77, of Jefferson, died at his home on March 23. He had practiced in Jefferson since 1927. Dr. Jongewaard received his M.D. degree from the University of Illinois in 1918 and served in both World Wars I and II. He was a member of the American Medical Association, the Iowa Medical Society, and a charter member of the American Academy of General Practitioners. In 1969 Dr. Jongewaard was honored by the American Medical Association and the Iowa Medical Society for his 50 years of practice.

Dr. Gordon N. Best, 74, of Council Bluffs, died at a local hospital on May 7, 1970, after an extended illness. Dr. Best was a graduate of Rush Medical School in Chicago and began his medical practice in Council Bluffs in 1926. He was on the medical staff at the University of Nebraska Hospital in Omaha and Jennie Edmundson Memorial Hospital in Council Bluffs. Dr. Best served as medical instructor at the University of Nebraska in the School of Internal Medicine from 1926-1942, and was assistant professor of medicine at the University from 1942-1954. He was a veteran of World War I and during World War II was on the examining staff at Offutt Air Force Base. He was a member of the American Board of Internal Medicine, Iowa Clinical Society, American College of Physicians, Pottawattamie County Medical Society, Iowa Medical Society and American Medical Association.



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Campbell Soup Company 404A
Casualty Indemnity Exchange 435

Dow Chemical Company 426A

Hoechst Pharmaceuticals 412
Hynson, Westcott & Dunning, Inc. 375

Lederle Laboratories 377
Lilly, Eli, & Company 373, 388

Medical Protective Company 426

National Drug Company 374, 418A, B
National Safety Council 384

Pfizer, Chas., & Company, Inc. 378-380
Poythress, Wm. P., & Company 410A, 426B
Prouty Company 428

Roche Laboratories 436
Robins, A. H., Co., Inc. 404D

Searle, G. D., & Company 404B, C
Seven-Up Bottlers of Iowa 429
Schering Laboratories 382A, B, C, D
Smith, Kline & French Laboratories 385

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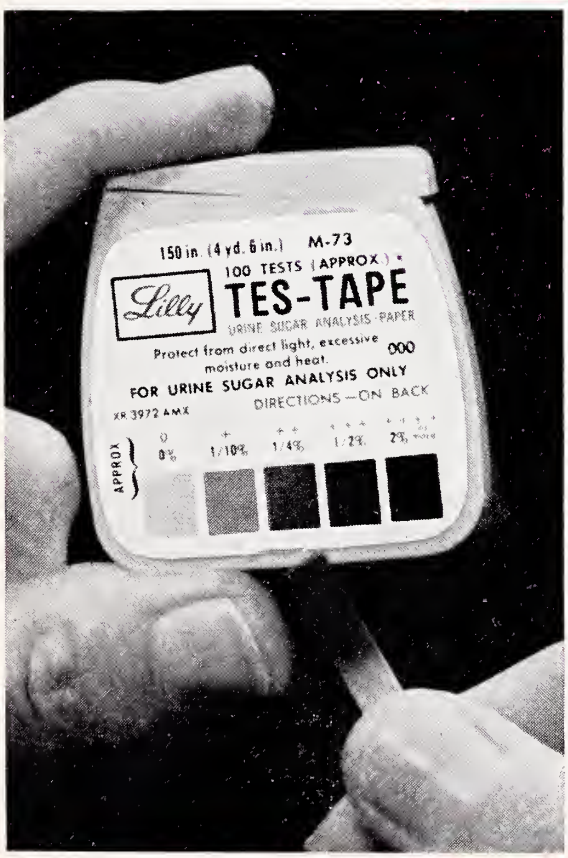
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The JOURNAL of THE IOWA MEDICAL SOCIETY

Vol. LX JULY, 1970 No. 7

CONTENTS

President's Address—
Medicine's Survival in the Seventies
W. M. Krigsten, M.D., Sioux City 443

Inaugural Remarks—
J. H. Sunderbruch, M.D., Davenport 446

President's Page 448

Proceedings of the 1970 Sessions of the House of Delegates, Iowa Medical Society 449

Reports of Officers 450

Report of Treasurer 452

Report of IMS Judicial Council 453

Reports of Standing Committees 454

Reports of Special Committees 466

Supplemental Reports, Board of Trustees . . . 479

Informational Report—Scanlon Medical Foundation/Iowa Medical Society 491

Supplemental Reports of Standing Committees . 493

In the Public Interest facing page 494

Supplemental Reports of Special Committees . . 503

Resolutions 506

Life and Associate Memberships 515

Reference Committee Reports 516

Fifty Year Club Members 531

County Society Officers 532

Officers and Committees of the Iowa Medical Society, 1970-1971 533

Index to Minutes 536

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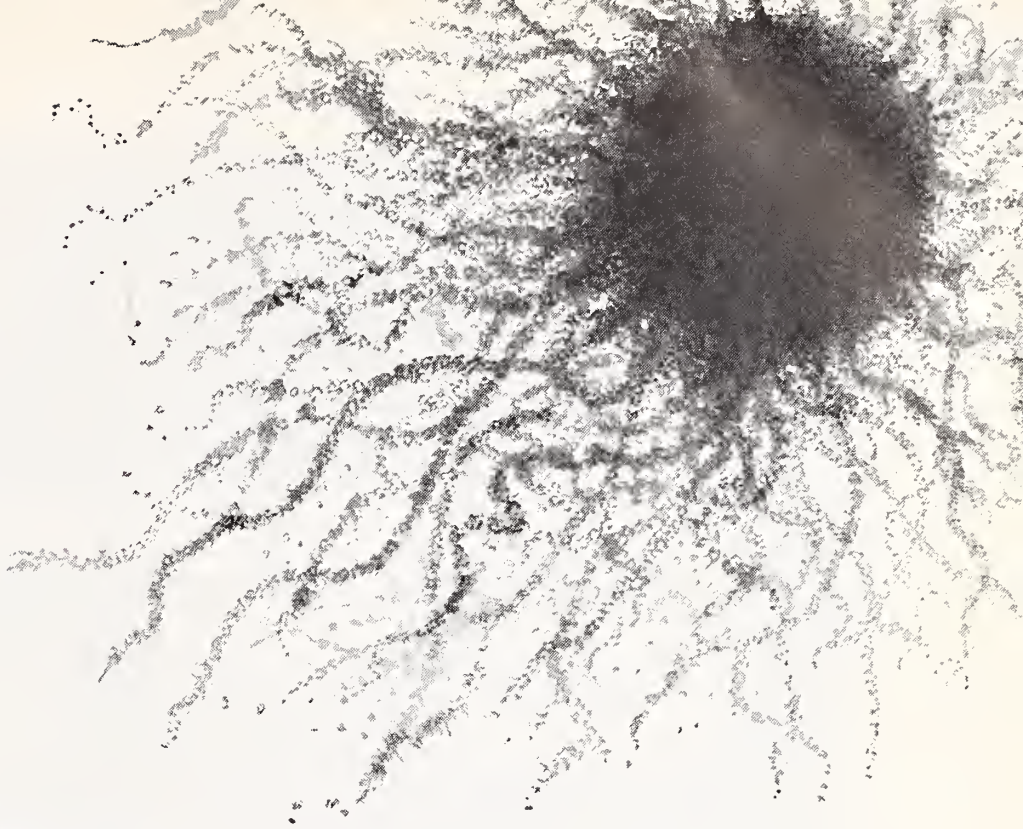
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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President's Address

Medicine's Survival in the Seventies

W. M. KRIGSTEN, M.D.
Sioux City

SURVIVAL IS TODAY'S HOTTEST SUBJECT. There's no doubt about it. No citizen capable of reading or hearing could have escaped the bombardment of concerned comment over man's future. Attention in all forms is being given to ecology, environment, population and pollution.

Survival is a *gravely* important subject; I use the pun for impact, not to make light of the matter. If mankind is to avoid the mass burial some are predicting, it can not take lightly the theories, the ideas, the concerns which are finding expression today.

Those of you who share my generation will admit that ours has largely been an optimistic one, marred to be sure by depression and by war. Nonetheless, the industrial revolution is our offspring. We have tended to regard every problem of mankind as one to be solved by technical ingenuity. We have directed overwhelming amounts of technology at the problems of production and distribution of goods. The results have been remarkable, at least in our chapter of history; we have achieved unprecedented levels with our mechanical and scientific prowess.

But we sense now that goods in abundance do not bring utopia. We see the benefits of technology back-firing—bringing some unwelcome by-products. We have devised an unparalleled industrial system—but one that pollutes the air and water needed to sustain life. Our products are producing new hazards to human health—in the form of radiation and contamination. Despite our abundance, despite our affluence, the quality of American life, particularly urban life, appears to be deteriorating. We are given to believe that our environmental problems are almost beyond remedy.

You probably have had opportunity to observe first-hand the deplorable conditions which exist in parts of the United States and in other countries. Yet, with me, you may find it difficult to sense the extreme urgency when you return to your Iowa home to find reasonably clean air, reasonably clean water and a population picture which is anything but mushrooming.

POPULATION DILEMMA

While we in Iowa are blessed, at least comparatively speaking, with wide open spaces, we can not ignore the experts' predictions. They say, for instance, that by the time of the country's bicentennial 80 per cent of our people will be living on one per cent of the land. If this prediction is accurate, the decade of the 70's will truly place us in the era of megalopolis. A study in the HARVARD BUSINESS REVIEW reports that $275 billion will be required over the next 34 years to assure clean air and water with this kind of population saturation. This will be needed to reverse and control water pollution, to abate and control air pollution, and to dispose of wastes. Is the nation's pocketbook equal to the strain?

It is becoming increasingly clear, if we are to have a life worth living, and if we are to bequeath to succeeding generations a world in which they too can find satisfaction, we are going to have to subdue this tiger we now have by the tail. Physicians are going to have to assume increasing amounts of leadership in stemming the tide of environmental deterioration. We cannot treat the symptoms of disease and ignore the cause.

Our dilemma is certainly not that of choosing one or the other: industrial magnitude or a healthful environment; industrial production or clean air; abundant food or water unpolluted by pesticides and fertilizers; nuclear energy or safety from radiation hazards. Our objective

This address was delivered by Dr. Krigsten on April 27 at the second of the General Sessions of the 1970 Annual Meeting of the Iowa Medical Society.

should be to that of finding a balancing equation—one which regards the total health and welfare of the whole man.

HEALTH CARE DELIVERY

The health care delivery system is feeling the pulls and tugs of many forces, and this seems certain to continue indefinitely. We hear endless commentary about the inflationary cost of health care; the methods of covering this burgeoning cost; the problems of health manpower; the financing of necessary facilities; the proper location and utilization of these facilities. These, in the main, are the subjects about which we are concerned, about which we are apprehensive.

The January 17 issue of BUSINESS WEEK carried a special report entitled, "The $60-Billion Crisis Over Medical Care." The opening paragraphs of this article carry an ominous prediction. I quote:

"A lot of Americans would rather die than get seriously sick. For millions, going to the hospital means going broke or close to it. For many more, good medical care is nonexistent.

"Private health insurance plans, with a large measure of business support, have helped to ease the pains in recent years. So have Medicare and Medicaid. But pressure is mounting for far more sweeping changes in the way Americans get their medical care, and the answer looks more and more like the one adopted by practically every other major Western country: a national health program.

"Many people still regard Medicare and Medicaid as incipient socialized medicine. They haven't seen anything yet. Before the end of this decade, the federal government will almost certainly get deeply into the health insurance business by sponsoring a program that will cover everyone in the country."

How does this forecast strike you? A better question might be: What are the political realities of the day? How do things look for Iowa physicians? There are Iowa doctors who damn the government at every turn. This is their right. They say "no dice" to anything with a government connection. There are others, *fortunately few hereabouts,* who say, "Let big brother run the show, we'll take orders, draw our pay, and forget the falderal."

THE IOWA PHYSICIAN

There's danger of course in generalization. Just the same, the Iowa doctor typically is working 70, 80 or more hours a week; he wants to care for his patients the way he thinks they ought to be cared for, not the way some distant unknown tells him; he believes health care should be available to those who can't afford it (this has long been the position of the Iowa Medical Society); he's frustrated by governmental minutia and by not knowing what to do about it; he reads about universal health plans, touted by Rockefeller, Javits and others.

The Iowa doctor has likely been involved in the long battle against a full-fledged governmental take-over of health care. He may have despaired in 1965 when Medicare became law. He may have accepted the "foot's-in-the-door" line of thinking and said dejectedly, "It's only a matter of time now before we have total government medicine."

Socialized medicine. State medicine. Whatever you want to call it. To the typically independent thinking Iowa physician, it is a revolting option. Is it close at hand? Yes, according to some forecasters. But I say unequivocally it is still worth our total resistance. The ballot box represents our front line of defense.

Washington is immersed in medical aid for the aged, the veterans, and some of the poor. Still, as many have predicted, a growing body of influential opinion believes this is just not enough. They have described Medicare and Medicaid as the overture. What is needed now, they say, is a nationalization of the total health care system.

When Medicare was enacted in 1965, there were few who believed that the federal government's interest would stop there. Most expected only a breathing spell before the national debate erupted again—this time on how to finance the health care costs for the balance of the population. The decade of the 70's will provide the time span for this debate.

NATIONAL HEALTH INSURANCE

Much has already been said in the press about a national health insurance system. Articles have referred to the plan of Walter Reuther and the Committee of 100; to Senator Edward Kennedy's promise to introduce a bill; to

Senator Javits' plan for health care financing; to Missouri Congressman Hall's two-part health insurance program; to the AFL-CIO plan to broaden Medicare and extend it to all ages; and to the Medicredit bill of the American Medical Association.

Briefly, for your information, the AMA Medicredit bill does not disturb the Medicare program; it would cover only persons under 65. The AMA program would allow individuals and families to purchase comprehensive health insurance coverage on a voluntary basis. Those in the lower 30 per cent tax liability group (approximately 30 per cent of the population) would receive certificates entitling them to the comprehensive health plan policies, without cost. Those above the lower 30 per cent level would receive a tax credit ranging from 10 per cent to 98 per cent depending on their economic status. The AMA program calls for a Health Insurance Advisory Board to set guidelines to be used by the states in approving and qualifying plans and insurance companies.

Of the several proposals now being discussed the AMA plan is reported to be the only one actually in bill form. It is sponsored by Senator Fannin of Arizona and Representative Fulton of Tennessee.

At the other end of the spectrum, the Committee for National Health Insurance or the Committee of 100 has devised a plan that calls for broad and sweeping changes in the health care system. This is called, for short, the Reuther Plan. This plan provides virtually every kind of medical care for virtually everyone in the country. It would be financed by getting two-thirds of the money needed from social security payroll taxes and one-third from general federal revenues. The whole operation would be put under the wing of a special office in HEW, and this office would swallow up the present federally-backed programs. The proponents have said there would be ways of controlling costs and controlling the quality of medical care.

DECADE OF SEVENTIES

In the decade of the 70's the advocates of change in the health care system will use Congress, more than ever before, as a forum to attack the present medical care system. Just how soon and how intensely a national health insurance system will be considered is dependent on several factors: the rate of future medical cost increases, the makeup of future Congresses, and the relative strengths of the several Washington lobbies. The most telling of these will probably be the rate of increase of medical costs.

When the House Ways and Means Committee schedules hearings on Medicare and Medicaid changes, the wrappings will come off the various plans and debate will begin. Except as they relate to Medicare and Medicaid, the plans are not excepted to receive serious consideration this year. More likely, they will form the framework of the debate which can be expected to continue for some time.

Some of the important questions which must be resolved during this debate are:

What role, if any, *shall be assigned to the federal government in financing the expense of health care for the* total *population?*

Shall the federal government provide direct care or shall it limit its involvement to financial assistance and use private health insurance for carrying out the program?

Shall funding be by way of general tax revenues or through a special tax such as payroll or social security?

Should there be coverage for all persons, uniformly, or shall the program in some way reduce federal financial participation when the individual has no financial problems?

And finally, shall the program be one aimed at helping to finance health care costs or shall it be one whose real purpose is the restructuring of the whole health system, with emphasis on federal controls of care and charges?

These are the ominous and pressing questions which each of us must ponder.

In Washington, D. C., on April 9, several of your Society officers conferred with members of the Iowa Congressional delegation on Medicare and Medicaid and on future involvement of government in the delivery of health care. Let me conclude by mentioning that in this discussion extensive reference was made by your officers to the importance of professional peer review. Attention was drawn to a passage in a new informational folder prepared by the Society on the subject of peer review. It de-

clares in clear terms that the Iowa Medical Society is prepared to act as a positive force (1) to conserve health care dollars, (2) to educate and inform the public and medicine regarding the economics of health care, (3) to assure the appropriate use of health care personnel and facilities, and (4) to preserve and enhance high standards of medical practice in the State of Iowa.

Our survival in the seventies is hinged in large measure to the manner in which you and I fulfill this four-fold commitment.

Inaugural Remarks

J. H. SUNDERBRUCH, M.D.
Davenport

SOCIETY PRESIDENTS have frequently used these few minutes to summarize the problems confronting medicine. Like my predecessors, I certainly acknowledge the magnitude of our problems. I think it is healthy to have this kind of an awareness. It is my hope that during the ensuing year we can meet our problems head-on; that we can do so with insight and vision, so as to provide a suitable climate for those who follow us.

To do this, we, the providers of health care, must thoroughly understand the desires and the needs of the consumers of health services. In addition we must consult and cooperate with those who have a dedicated desire to assist us in our efforts.

Historically, the Iowa physician has assumed responsibility for the physical well-being of his patient. The family physician has gone beyond this on many occasions, to serve the social ills of the patient and other members of his family; in other words, he has served the family as a total entity.

With specialization, the physician has become more adept at caring for specific parts of the total patient, so much so that the mental and social problems are now cared for by the psychiatrist. One of the shortcomings of specialization is the demise of the total concept of health care. To compound this problem, we have fewer "town physicians" who participate actively in school board, Chamber of Commerce, PTA and other community functions.

Delivered at the IMS Annual Meeting, April 29, 1970.

What I am saying is that a by-product of the increase in medical knowledge and specialization has been a corresponding decrease in the physician's consideration of the patient's total role in society. Associated with this is an increasing lack of attention by the physician to the broad social ills of our day. We cannot divorce ourselves from the broad ills of society.

In the eyes of the public, our lack of participation in the ills of society is likely our most significant shortcoming. As individuals, physicians are held in high esteem by their patients, but as a profession we see this esteem losing some of its lustre. I ask for your renewed participation in the treatment of the ills of society.

Most of us in the medical profession today have a frustrating time trying to understand those in the non-work society who live for today and do not plan for tomorrow. Our association with those who look to others for their welfare and livelihood is of relatively short duration, and it is one which is most difficult to comprehend. Some of us have learned to accept this sad reflection on society; most of us are concerned about it in relation to the future.

The methods of delivering medical care have changed for several reasons; principally perhaps because of the entry or intervention of the third party, notably the government. As providers of care, we are conscious of various factors bearing on the health delivery dilemma: 1) The physician shortage; 2) The population explosion; 3) The knowledge explosion; and 4) The remarkable increase in the sophistication and intelligence of the patient.

All of these considerations bear on the image ascribed to us by the public.

I refer you to the Himler Report of the AMA. Here is evidence of the great distur-

bance, not only relating to the public, but within our profession. This subject has been considered, as you well know, these past several days.

I also refer you to the rebellion of students in medical schools. Those of us who have had some experience with students will attest to the fact that present-day problems are not myths.

Personally, I am an activist. That is, I am willing to try new things, to seek new answers to problems. However, I remain a firm believer in the free enterprise system; I still feel there is a place for fee-for-service in the practice of medicine. However, I believe it behooves the medical profession to experiment with new methods, to test approaches which have not been thought of. We need to seek various solutions to our problems.

We must associate with medical students, with our medical schools, with osteopaths, with voluntary agencies and with governmental agencies. All of these entities can assist in this period of experimentation. Above all, we must consider the consumer, the patient.

I feel we in Iowa can adapt the Foundation concept described in the report of the Board of Trustees. I would hope that we can actively pursue this in the future weeks. We have an ad hoc committee to study new methods of delivering health care in rural areas. I plead with each and every one of you to increase your efforts to help the medical profession be among the leaders in our communities, as we face the dilemma of providing health care.

We have the tools to pave the way. I extend to you this challenge and I assure you that, as President of the Iowa Medical Society, I will expend all of my efforts to assist each and every one of you in this endeavor.

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President's Page



The privilege of this office has enabled me to attend state medical meetings in Wisconsin, Minnesota, Ohio and Illinois. The experience has been invaluable. On such junkets one quickly realizes the problems of the profession do not change significantly with state boundaries. We all seem afflicted by splinterization; by lethargy in terms of informing ourselves about key issues; by localization or isolationism, i.e., spending too much time on an individual issue while frequently ignoring broad community problems.

Today's medical students, our replacements, are deeply immersed in the problems of society; these students are an important part of the oncoming and frequently perplexing younger generation. Do they see us as unrealistic, unapproachable, unresponsive? I think not.

We obviously have a real responsibility to these young men and women. We must conduct our practices and represent our profession in a manner worthy of emulation. We must support the youthful energy and dedication of those who will follow us. In short, we must share our experience and our expertise; we must be the kind of practitioners with whom our successors will proudly identify.

President

PROCEEDINGS OF THE 1970 SESSIONS OF THE HOUSE OF DELEGATES

Iowa Medical Society

Des Moines, Iowa—April 26-29, 1970

(Alphabetical Index Can Be Found on Page 536)

SUNDAY SESSION, APRIL 26, 1970

The House of Delegates of the Iowa Medical Society was called to order by the Speaker, Dr. L. D. Caraway, of Monticello, at 9:20 a.m., Sunday, April 26. The House of Delegates approved the taking of attendance by signed registration cards. There were 100 delegates, 10 voting alternates and 21 ex-officio members present.

County	*Delegate*	*Alternate*
Adams		C. L. Bain
Allamakee		C. R. Rominger
Appanoose	E. A. Larsen	
Audubon	H. K. Merselis	
Benton	P. J. Amlie	
Black Hawk	C. D. Ellyson	
	D. E. Conklin	
		J. L. Shreffler
	G. R. Clark	
Boone	E. E. Linder	
Bremer	V. H. Carstensen	
Buchanan	L. J. Flage	
Buena Vista	Arthur Ames	
Butler	F. A. Rolfs	
Calhoun	R. P. Ferguson	
Carroll	J. M. Tierney	
Cass	K. R. Swanson	
Cerro Gordo	A. J. Herlitzka	
	J. Y. Hendricks	
	H. E. Cahoy	
Cherokee	R. D. Berge	
Chickasaw	J. D. Carr	
Clarke	J. D. Kimball	
Clayton	E. G. Kettlekamp	
Clinton	K. R. Sorenson	
	G. R. Schmunk	
Crawford	D. J. Soll	
Dallas-Guthrie	W. A. Castles	
	W. A. Seidler	
Decatur-Ringgold	E. E. Gamet	
	D. E. Mitchell	
Delaware	J. E. Tyrrell	
Des Moines	J. F. Foss	
	G. L. Smith	
Dickinson	D. F. Rodawig, Jr.	
Dubuque	K. K. Hazlet	
		J. A. Pearson
		J. W. White
Fayette	R. S. Jaggard	
Floyd	D. L. Trefz	
Fremont	F. M. Ashler	
Grundy	M. P. Vanden Bosch	
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Hardin	T. C. Graham	
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	J. J. Keith	
	C. R. Aschoff	
	W. J. Robb	
	R. A. Sautter	
Mahaska	G. W. Bennett	
Marion	Peter Van Zante	
Marshall	L. O. Goodman	
	W. T. Shultz	
Mitchell	R. G. Boeke	
Monona	J. L. Garred	
Montgomery	Oscar Alden	
Muscatine	K. E. Wilcox	
O'Brien	J. C. Peterson	
Palo Alto	H. L. Brereton	
Plymouth	J. P. Trotzig	
Pocahontas	J. B. Thielen	
Polk	M. R. Saunders	
	M. H. Dubansky	
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Tama	A. J. Wentzien	
Union-Taylor	R. H. Kuhl	
Wapello	R. P. Meyers	
		L. E. Coppoc
Washington		C. W. Beckman
Wayne	K. A. Garber	
Webster	L. J. O'Brien	
	F. D. Lawson	
Winneshiek	T. F. Dynes	
Woodbury	C. L. Beye	
	L. H. Boggs	
	P. M. Cmeyla	
	R. C. Larimer	
Worth	B. H. Osten	
Wright	D. A. Harding	

LIAISON DELEGATES

S. P. Leinbach — J. M. Rhodes

OFFICERS PRESENT AS EX-OFFICIO MEMBERS OF THE HOUSE

W. M. Krigsten	L. D. Caraway
J. H. Sunderbruch	L. W. Swanson
A. J. Havlik	H. J. Smith
V. L. Schlaser	E. M. Smith
T. A. Burcham	H. L. Skinner
K. E. Lister	J. W. Eckstein
R. L. Wicks	R. F. Birge
J. F. Paulson	O. D. Wolfe
H. G. Marinos	C. V. Edwards, Sr.
H. E. Rudersdorf	C. W. Seibert
G. A. Fry	

Minutes of the April 30, 1969 meeting of the House of Delegates were approved as published in the July, 1969, JOURNAL OF THE IOWA MEDICAL SOCIETY.

The Speaker of the House of Delegates introduced physicians who were serving in the House for the first time, and also the individuals who were seated at the head table. He announced Reference Committee appointments.

Reports in the 1970 HANDBOOK FOR THE HOUSE OF DELEGATES were approved as published, except the eight resolutions beginning at page 87, since they were to be presented at a later time under the heading of new business; and the Report of the Committee on Sports Medicine beginning at page 80. This report was referred to the Reference Committee on Legislation and Miscellaneous Business.

(Following are the reports previously published in the 1970 HANDBOOK FOR THE HOUSE OF DELEGATES.)

Reports of Officers

FROM THE OFFICE OF THE SECRETARY

The Secretary of the Iowa Medical Society is responsible for maintaining membership and dues records; conducting the official correspondence, notifying members of meetings, officers of their election, and committee members of their appointments and duties; and preparing minutes of all official meetings of the Society. All methods of communication are utilized to aid the district councilors in organizing and improving the component societies, and in extending the influence and usefulness of the IMS.

The following paragraphs highlight some of the more important activities of the office of the secretary:

1970 ANNUAL MEETING

A new approach has been taken by the Annual Meeting Program Committee in an effort to involve the members actively in small-group teaching-learning sessions. The entire program on Monday will concern clinical problems confronting the physician, and there will be 16 half-hour seminars scheduled for the afternoon. On Tuesday, attention will be focused on environmental problems. The complete program for the Annual Meeting appeared in the March issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

District councilors have received cooperation from the headquarters office in organizing their caucuses in preparation for the Annual Meeting, and in preparing for the meeting of the Nominating Committee.

HOUSE OF DELEGATES

The proceedings of the 1969 sessions of the House of Delegates were published in the July, 1969, JOURNAL. The usual administrative procedures in implementing directives of the House of Delegates have occurred. The delegates are reminded that the first session of the House of Delegates will be held on Sunday, April 26, at 9:00 a.m. in the Grand Ballroom of the Hotel Fort Des Moines. This is a departure from past years, when opening House of Delegates sessions have been held at the Savery Hotel. The move became necessary because of schedule conflicts. Reference committee hearings will also be conducted at the Hotel Fort Des Moines on Sunday, and they will begin as soon as possible following adjournment of the House. The final session of the House of Delegates is to take place at 8:00 a.m. on Wednesday, April 29, at the Savery Hotel.

EXECUTIVE COUNCIL

The Executive Council, the Society's interim policy-making body, has met on three occasions since the 1969 Annual Meeting, and a fourth session is scheduled on April 16. In addition, action on one specific item was taken by mail ballot. Information on important IMS projects and activities has been provided to members of the council. Special newsletters and the monthly IMS REPORT have been utilized to inform state and county medical society officers, delegates, deputy councilors and other leaders about the many deliberations and actions of the Executive Council, as well as about various committee activities and other items of special interest.

JUDICIAL COUNCIL

The Judicial Council has met three times during the past year, and a fourth meeting is scheduled for April 15. J. F. Bishop, M.D., chairman of the Judicial Council, has prepared a report on the activities of that body, which appears elsewhere in this HANDBOOK. The principal responsibilities of the Judicial Council are to approve applications for IMS membership, to decide various questions relating to membership or ethics; and, if necessary, to discipline members of the Society.

A dinner for members of the Board of Trustees and of the Judicial Council is held on the evening prior to Executive Council sessions, and then the two bodies conduct their business meetings separately. At the joint meetings, special guests have been invited to discuss topics of immediate concern. James Speers, M.D., former Iowa Commissioner of Health, attended one dinner session and discussed matters pertaining to mass immunization programs, and at another session, Mr. Bernard D. Hirsh, general counsel for the AMA, presented information on malpractice-insurance programs and problems.

BOARD OF TRUSTEES

There have been 10 meetings of the Board of Trustees since the last session of the House of Delegates, and three more are scheduled prior to the Annual Meeting. In addition, arrangements have been made for a joint meeting of the IMS Board of Trustees and the Executive Committee of the Blue Shield Board of Directors. The IMS executive staff maintains almost daily contact with the chairman of the Board of Trustees and/or other officers of the Society.

COMMITTEES

Reports from the 50 standing and special committees of the Iowa Medical Society appear in this HANDBOOK and some of those committees will also present supplemental reports when the House of Delegates convenes in April. Over 75 official committee meetings have been held in the Society's headquarters building during the past year, and several others are scheduled to occur prior to the Annual Meeting. That

total does not include informal sessions between committee members and staff, or telephone conferences.

LIAISON WITH COUNTY MEDICAL SOCIETIES

The IMS REPORT continues to be distributed each month to county medical society presidents and other officers in an effort to keep them informed about current problems facing medicine, as well as projects of the IMS. A conference for county medical society officers was not held this past fall, but emphasis was placed on the series of 14 area meetings which were held throughout the state for the purpose of considering matters pertaining to the delivery of health care in Iowa. The county medical society officers received a special invitation and were encouraged to attend these sessions, which were attended by other professionals and allied health personnel, and community leaders as well. The meetings were sponsored by the IMS, the U. of I. College of Medicine and the Health Planning Council of Iowa, with the cooperation of the Iowa State University Extension Service.

IMS FIELD SERVICE

The integrated IMS/BS Field Service program, which became operative on May 1, 1968, is serving a valuable function and has achieved great success, according to the statements that have been made by physicians throughout the state. Under this program, six field men confer with county medical society officers and member physicians on matters of interest to the medical profession and Blue Shield. Mr. Eldon Huston, the assistant executive vice-president of the Society, directs the joint IMS/BS field service activities.

MAILINGS

The Society utilizes news bulletins, legislative bulletins and the IMS JOURNAL in keeping the membership informed and up-to-date on important programs and issues of the day. These materials are in addition to the voluminous amount of daily correspondence emanating from the headquarters office.

NATIONAL, REGIONAL AND STATE CONFERENCES

Following is a list of some of the major conferences and meetings at which the IMS was represented during the past year: AMA—Annual and Clinical Meetings, Congress on Occupational Health, Annual Conference of State Medical Society Mental Health Representatives, Congress on Medical Education, National Congress on Socio-Economics of Health Care, Conference on Rural Health; Regional Workshop for State Chairman of Medicine and Religion Committees, Congress on Medical Ethics, AMPAC Conference and IMS Legislative Conference, Midwestern Conference on Voluntary Health Agencies, Conference on Physicians and Schools, Woman's Auxiliary Fall Conference, Regional Conference on Quackery, Orientation Conference for New Medical Society Executives, AMA-AMPAC Workshop, Meeting of Advisory Committee to AMA Executive Vice-President, Conference for Senior Medical Executives, North Central Medical Conference, SMJAB Journal Conference, Annual Meeting of the Iowa Academy of General Practice, National Pharmaceutical Council, Mid-year Meeting Pharmaceutical Manufacturers Association; National Blue Shield Annual Program Conference, Annual Meeting Iowa Medical Service (Blue Shield), Blue Cross Board of Directors.

IOWA REPRESENTATIVES AT THE NATIONAL LEVEL

The Society maintains close liaison with the AMA at the officer and staff level. Several members of the IMS serve on AMA councils and committees, including:

D. F. Ward, M.D., Dubuque, Iowa, Council on Legislative Activities.

R. A. Berger, M.D., Davenport, Iowa, Committee on Quackery.

H. J. Smith, M.D., Des Moines, Iowa, Committee on Government Medical Services.

Robert G. Carney, M.D., Iowa City, Iowa, Committee on Cutaneous Health and Cosmetics.

W. C. Keettel, M.D., Iowa City, Iowa, Residency Review Committee—Obstetrics and Gynecology.

Dean M. Lierle, M.D., Iowa City, Iowa, Residency Review Committee—Otolaryngology.

Daniel B. Stone, M.D., Iowa City, Iowa, Archives of Internal Medicine.

William B. Bean, M.D., Iowa City, Iowa, Archives of Internal Medicine.

R. H. Flocks, M.D., Iowa City, Iowa, Residency Review Committee—Urology and Interspecialty Committee.

Four IMS staff members are active in the American Association of Medical Society Executives, and Mr. Donald L. Taylor, the IMS executive vice-president, is a past-president of that organization. Mr. Taylor also was recently appointed to a five-year term on a newly created Advisory Committee to the AMA Executive Vice-President.

SERVICES TO WOMAN'S AUXILIARY

The Woman's Auxiliary to the Iowa Medical Society utilizes the facilities and services of the Society in developing and implementing various projects, with assistance from Mrs. Hazel Lammey, a member of the executive staff. The staff also cooperates with the Auxiliary in arranging its annual meeting and board of directors' sessions, in preparing its annual reports, in maintaining its membership records, and in preparing and distributing the WOMAN'S AUXILIARY NEWS.

Major projects of the Auxiliary during the past year included sponsorship of a continental breakfast for wives of all members of the state legislators and executive officers, and in addition, a special workshop for county Auxiliary officers and committee chairmen.

IMS MEMBERSHIP

Iowa Medical Society membership for the year 1969 totaled 2,411. Of this number, 217 held active dues-exempt membership as Life Members, Residents, or Members in Military Service, and 62 Associate Members were exempt from the payment of dues. There were 66 counties (in 62 single or two-county societies) in which 100 per cent of the County Society members held membership in the IMS. Physicians ineligible for membership numbered 45, and there were 99 eligible non-members in Iowa. The number of retired or not-in-practice physicians decreased to 77. The percentage of eligible physicians who held IMS memberships was 96 for the year.

COUNTY SOCIETIES HAVING 100 PER CENT MEMBERSHIP IN IMS IN 1969

Adair	Franklin	Madison
Adams	Fremont	Mahaska
Allamakee	Greene	Marshall
Appanoose	Grundy	Mitchell
Audubon	Hamilton	Monona
Benton	Hancock-Winnebago	Monroe
Boone	Hardin	Montgomery
Buena Vista	Harrison	Muscatine
Butler	Henry	Osceola
Carroll	Howard	Page
Cedar	Humboldt	Plymouth
Cerro Gordo	Ida	Pocahontas
Chickasaw	Iowa	Sac
Clarke	Jackson	Shelby
Clay	Jasper	Sioux
Crawford	Jefferson	Tama
Dallas-Guthrie	Kossuth	Union-Taylor
Davis	Lee	Van Buren
Decatur-Ringgold	Lucas	Wayne
Delaware	Lyon	Winneshiek
Dickinson		Wright

1969 IMS MEMBERSHIP RECORD

County	Active Members	Associate Members	Resident Members on Resident License	Eligible Non-Members	Ineligible Non-Members	Not in Practice or Retired	Percentage
Adair	1	1	..	..	..	..	100
Adams	4	..	..	..	..	..	100
Allamakee	9	..	..	..	..	1	100
Appanoose	8	1	..	..	..	2	100
Audubon	3	..	..	..	..	..	100
Benton	12	..	..	..	..	..	100
Black Hawk	122	4	..	2	..	2	98
Boone	18	1	..	..	..	..	100
Bremer	14	..	..	1	..	1	93
Buchanan	17	..	..	1	6	..	94
Buena Vista	14	..	..	..	..	..	100
Butler	6	..	..	..	..	..	100
Calhoun	10	..	..	1	..	1	91
Carroll	22	1	..	..	..	..	100
Cass	8	..	..	1	..	1	89
Cedar	8	..	..	..	..	..	100
Cerro Gordo	72	1	..	..	..	..	100
Cherokee	19	..	..	3	8	..	86
Chickasaw	7	..	..	..	..	..	100
Clarke	7	..	..	..	..	..	100
Clay	10	..	..	..	..	..	100
Clayton	6	1	..	2	..	1	78
Clinton	38	1	..	5	1	1	89
Crawford	10	..	..	..	..	..	100
Dallas-Guthrie	22	2	..	..	3	..	100
Davis	14	..	..	..	..	..	100
Decatur-Ringgold	7	..	..	..	..	1	100
Delaware	7	..	..	..	..	2	100
Des Moines	54	1	..	2	..	..	96
Dickinson	8	1	..	..	..	..	100
Dubuque	65	2	..	7	..	..	90
Emmet	14	..	..	2	..	..	88
Fayette	16	2	..	1	..	1	95
Floyd	18	..	..	1	..	..	95
Franklin	7	..	..	..	..	..	100
Fremont	4	..	..	..	..	..	100
Greene	8	..	..	..	..	..	100
Grundy	5	..	..	..	..	..	100
Hamilton	9	..	..	..	..	..	100
Hancock-Winnebago	14	..	..	..	1	1	100
Hardin	12	1	..	..	..	..	100
Harrison	6	..	..	..	..	3	100
Henry	18	..	..	..	6	2	100
Howard	7	..	..	..	..	..	100
Humboldt	6	..	..	..	..	..	100
Ida	2	..	..	..	..	1	100
Iowa	10	..	..	..	..	..	100
Jackson	12	..	..	..	..	..	100
Jasper	21	..	..	..	..	1	100
Jefferson	11	..	..	..	..	..	100
Johnson	274	2	..	17	..	4	94
Jones	12	..	..	2	..	1	86
Keokuk	5	..	..	1	..	..	83
Kossuth	10	..	..	..	..	..	100
Lee	41	2	..	..	..	..	100
Linn	132	10	..	12	..	3	92
Louisa	1	..	..	1	..	..	50
Lucas	2	..	..	..	..	..	100
Lyon	6	..	..	..	..	..	100
Madison	4	..	..	..	..	..	100
Mahaska	17	..	..	..	..	..	100
Marion	13	..	..	4	8	2	77
Marshall	42	..	..	..	..	1	100
Mitchell	11	..	..	..	..	1	100
Monona	9	..	..	..	..	1	100
Monroe	3	..	..	..	..	..	100
Montgomery	11	..	..	..	..	..	100
Muscatine	16	1	..	..	1	1	100
O'Brien	11	..	..	1	..	..	92
Osceola	3	..	..	..	..	..	100
Page	18	..	..	..	7	..	100
Palo Alto	10	..	..	1	..	..	91
Plymouth	9	1	..	..	..	..	100
Pocahontas	7	..	..	..	..	1	100
Polk	318	13	3	7	1	22	98
Pottawattamie-Mills	67	..	..	2	3	3	97
Poweshiek	9	..	..	3	..	..	75
Sac	7	..	..	..	..	..	100
Scott	110	2	..	3	..	5	98
Shelby	9	..	..	..	..	1	100
Sioux	11	..	..	..	..	1	100
Story	58	3	..	3	..	1	95
Tama	8	..	..	..	..	..	100
Union-Taylor	15	1	..	..	..	..	100
Van Buren	3	..	..	..	..	..	100
Wapello	39	1	..	1	..	2	98
Warren amalgamated with Polk							
Washington	9	..	..	1	..	..	90
Wayne	1	1	..	..	..	1	100
Webster	56	..	..	1	..	3	98
Winneshiek	12	..	..	..	..	..	100
Woodbury	108	5	..	9	..	..	93
Worth	3	..	..	1	..	..	75
Wright	14	..	..	..	..	1	100
TOTALS	2,346	62	3	99	45	77	96

AMA MEMBERSHIP

The members of the Iowa Medical Society who were active members of the American Medical Association in 1969 numbered 2,303. (This number includes active members who were dues-exempt because of life membership, residency or military service.) In addition, 62 held associate memberships, and two (working in Veterans Administration Hospitals) held service memberships in the AMA.

The 2,303 AMA memberships in 1969 entitled Iowa to three AMA delegates. In 1969 the Iowa AMA membership was 96 per cent of the total Iowa Medical Society membership.

V. L. SCHLASER, M.D., *Secretary*

REPORT OF THE TREASURER

The following financial statements set forth the fiscal status of the Iowa Medical Society as of December 31, 1969.

The 1969 Iowa Medical Society income exceeded expenses by $6,229.41.

IOWA MEDICAL SOCIETY

Balance Sheet—December 31, 1969

ASSETS

Current Assets:		
IMS Checking Accounts		$ 9,363.93
Prepaid Expenses		2,200.00
CHAMPUS		5,000.00
Notes Receivable (Baldridge-Beye)		750.00
Pension and Disability Insurance—Due from Employees		1,593.97
Investments		22,944.96
Total Current Assets		$ 41,852.86
Fixed Assets:		
Land		$ 73,875.00
Building	$308,141.16	
Office Furniture & Equipment	35,054.77	
Less: Reserve for Depreciation	-97,365.00	245,830.93
Net Fixed Assets		$319,705.93
TOTAL ASSETS		$361,558.79

LIABILITIES AND NET WORTH

Liabilities:		
Notes Payable		$ 30,000.00
Mortgage Payable		105,849.43
Accrued Mortgage Interest		2,425.72
Accrued Personal & Property Tax		11,200.00
Deferred Compensation		22,944.96
Deferred Income		9,778.00
Baldridge-Beye Memorial Fund: Note 12-31-69		750.00
Total Liabilities		$182,948.11
Net Worth:		
Balance 1-1-69	$172,381.27	
Add: Net Excess of Income over Expenses 1969	6,229.41	
Balance Net Worth		$178,610.68
TOTAL LIABILITIES AND NET WORTH		$361,558.79

IOWA MEDICAL SOCIETY
STATEMENT OF INCOME AND EXPENSES

For the Year Ended December 31, 1969

Income for the Year 1969:	
Dues—State Society	$319,646.25
Interest on Investments	2,221.75
CHAMPUS	2,651.46
Miscellaneous	512.50
AMA Collection Commission	1,445.50
Total Income	$326,477.46
Expenses for the Year 1969:	
Annual Session (Net)	$ 3,929.76
Council Expense	2,250.92
County Society Services	510.54
Depreciation—Building & Equipment	32,400.00
Dues and Subscriptions	2,119.75
Field Service	9,146.63
General Administrative Expense	1,468.71
Insurance	4,838.42
Interest Expense	6,591.11
Journal (Net)	21,471.73
Legal Services	8,625.00
Lights, Gas & Water	5,725.87
Office Stationery & Supplies	6,550.11
Pension & Disability Insurance	7,490.75
Postage	5,838.28
Repairs & Maintenance	4,076.25
Salaries	95,174.88
Service Contracts—Machines	886.22
Taxes:	
Personal & Property	11,007.93
Social Security	5,119.61
Unemployment—Federal	275.29
Telephone & Telegraph	8,270.72
Travel—Officer	11,732.67
Travel—Salaried Employees	9,641.78
Trustee Expense	4,372.24
Woman's Auxiliary	946.57
Committee Expense	49,786.31
TOTAL EXPENSE	$320,248.05
Net Excess of Income over Expenses for 1969	$ 6,229.41

THOMAS A. BURCHAM, M.D., *Treasurer*

BOARD OF TRUSTEES REPORT

A detailed supplemental report will be presented by the Board of Trustees to the House of Delegates at its opening session on Sunday, April 26, 1970.

As has been its custom, the Board will provide an accounting of the various programs implemented by the Society during the past year, the financial status of the IMS and other pertinent matters.

KENNETH E. LISTER, M.D., *Chairman*

REPORT OF THE IMS JUDICIAL COUNCIL

The IMS Judicial Council has held its usual four meetings since last year's annual meeting, and it will hold another prior to this year's. At its organizational session which immediately followed adjournment of the 1969 House of Delegates, J. F. Bishop, M.D., was reelected chairman, and E. E. Gamet, M.D., was reelected secretary. The Fifth District Caucus had chosen Homer E. Wichern, M.D., to replace C. A. Trueblood, M.D., as its representative on the Council.

At each meeting of the IMS Judicial Council there are several membership matters for it to pass upon. In accordance with provisions of the IMS Articles of Incorporation and By-Laws, the councilors decide whether applicant doctors of medicine shall be admitted to membership. Actually, however, the councilors have been far more deeply concerned about getting newly established physicians to apply for membership and about getting doctors who have dropped their memberships to reinstate themselves. For these purposes, each councilor has been provided lists of new physicians and of former IMS members practicing in his district.

The one important requirement for readmission that a former member must satisfy is payment of IMS dues for the year in which he became delinquent, as well as dues for the year in which he applies for readmission. Though that rule may seem overly severe, it is absolutely essential, for if a member could refuse to pay

his dues, for one reason or another, and then could restore himself to membership the next year without penalty, the size of the Society and its income would fluctuate and its financial standing would be seriously endangered.

The Judicial Council asks the help of other IMS members, and particularly asks the help of all county medical society officers, in maintaining and enlarging the membership of the state society. The efforts of the IMS in promoting the health interests of all Iowans and in defending the freedom of physicians to serve those interests will be most effective if the organization can represent 97 or more per cent of the doctors of medicine in the state.

The Judicial Council was happy, at the 1969 Annual Meeting, to approve the hyphenation of the Pottawattamie and Mills County Medical Societies, and the councilors hope there will be more such mergers. Travel, nowadays, is relatively easy, and physicians in counties where there are few doctors could benefit greatly from the formation of district societies large enough to conduct scientific sessions on a regular basis.

As in past years, the individual members of the IMS Judicial Council settled several difficulties without first bringing them to the attention of the Council as a whole. One of them, this past year, had arisen when a physician was reluctant to answer another doctor's questions about a patient until the patient paid his bill. The use of leverage of that sort, of course, is not permissible, and the appropriate councilor called attention to the report of a similar case on pages 340-341 in the JOURNAL OF THE IOWA MEDICAL SOCIETY for April, 1969. Another difficulty arose when a county hospital arranged to employ a physician, on salary, to take charge of its emergency room and to perform referral surgery. The councilor for the district, together with the IMS legal counsel, pointed out that under Iowa law a hospital may not pay a surgeon a salary and collect from patients or insurance carriers for the operations that he performs. The councilor, together with the IMS legal counsel, also suggested an arrangement that would satisfy the provisions of the Iowa Code.

Another matter having to do with emergency-room staffing came to the attention of the Council as a whole, and the subsequent discussion, in which several councilors participated, served to indicate that such problems are widespread. Agreement was reached on several points. First, at hospitals lacking interns and residents, the medical-staff by-laws should require every attending-staff member to take his turn at covering the hospital's emergency room, and assuming responsibility for each patient until the patient's personal physician can be reached. It was pointed out that the AMA has published a pamphlet on emergency-room staffing, and it was decided that the IMS should obtain some copies of it for distribution.

At one of the Judicial Council's meetings, the new Truth in Lending Law was discussed, insofar as it may apply to physicians. Subsequently, a legal opinion on it was published on pages 717-718 of the August, 1969, JOURNAL OF THE IOWA MEDICAL SOCIETY. The Council was asked at its October meeting to decide upon the propriety of physicians' accepting payment for their services through credit-card plans. It decided that (1) there is nothing unethical about a physician's letting a patient decide how to pay his bills, and (2) that though the doctor may not, himself, charge and collect interest or penalties on overdue accounts, he is not responsible for the patient's having to pay extra amounts if he fails to settle with the credit-card firm or bank within 30 days.

The IMS Judicial Council has had a share in the IMS/ISOPS Evaluation and Enrollment Program, the arrangement by which osteopaths holding DO&S licenses are accepted as "individuals with whom it shall not be considered unethical for doctors of medicine to associate professionally." Approval by the IMS Judicial Council is the final step in that procedure, and in point of fact the recommendation of the local medical society in the county where the osteopath practices has never been turned down. But that does not mean that the Judicial Council has wielded a rubber stamp. On the contrary, there have been numerous occasions on which the Council has refused to act upon an application for any of several reasons.

During the past year the chairman was invited to meet with the Standing Committee on Articles of Incorporation and By-Laws when at the request of the House of Delegates that committee was to discuss the possible wordings of changes in IMS regulations so as to let county medical societies grant memberships of some sort to osteopaths. He conveyed the thoughts of his fellow-councilors to the Committee.

The chairman also represented the Council on two other occasions. In June, he spoke on medical ethics as they concern physicians' employees, at the annual meeting of the Iowa-Nebraska Clinic Managers Association, in Davenport.

And in October he attended a meeting in Chicago, called by the AMA Judicial Council, at which the members of that body sought ideas from state judicial council members regarding ways of reconciling the philosophies and attitudes of long-established physicians, on the one hand, and of the young men now entering the profession, on the other. In other words, the AMA Judicial Council acknowledged and sought suggestions about remedying a "generation gap" in the medical profession.

JAMES F. BISHOP, M.D., *Chairman*

Reports of Standing Committees

ARTICLES OF INCORPORATION AND BY-LAWS

The 1969 IMS House of Delegates adopted two items for consideration and report by this Committee to the House in 1970.

(1) Create a new Councilor District consisting of Polk and Warren Counties.

(2) Recommend changes in the IMS Articles of Incorporation and By-Laws to permit some type of membership in the IMS and component societies for qualified osteopaths.

The Committee has met with representatives of the Judicial Council and IMS Osteopathic Committee, besides establishing appropriate contacts with other states and AMA officials. It is apparent that throughout the United States varying types of action are being taken by medical organizations concerning relationships with osteopaths.

Appropriate amendments are being drawn to accomplish the charge given to this Committee. The Committee will be meeting prior to the Annual Meeting to review the specific language for submission to the 1970 House of Delegates in a Supplemental Report.

O. D. WOLFE, M.D., *Chairman*

GRIEVANCE COMMITTEE

If the effectiveness of a committee is in inverse proportion to the number of meetings called, the members of the Grievance Committee have some glimmer of hope. The decline in trivial complaints, which have usually flooded the docket, has been welcomed and may be taken as an indication that our yearly admonishing report has been taken to heart and communications have improved.

We have had to meet infrequently this year and hope that this trend will continue. To the faithful members who have braved adverse weather, I extend my appreciation and to the untiring secretary, D. O. Maland, M.D., goes credit for handling many matters by correspondence and telephone, thus sparing the committee the need for a meeting.

We urge all colleagues to keep us in mind as a committee which is happy when it does not have to meet. We believe all will agree it is mutually rewarding.

F. O. W. VOIGT, M.D., *Chairman*

COMMITTEE ON HEALTH EDUCATION

The Health Education Committee continues to keep apprised of developments with respect to the implementation of sex education programs. The delegates will recall that over a year ago a "Joint Policy Statement on Sex Education in Schools" was prepared and approved by the State Department of Public Instruction and the Iowa Medical Society. In the main, the Society, the Health Department and the Department of Public Instruction have taken the position that carefully planned and scientifically accurate sex education programs should be included and be made a definite part of the health education curricula of the elementary and secondary schools in Iowa. An editorial on this important subject was prepared by the Committee chairman last spring, and was published in the June 1969 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

In principle, at its 1969 Annual Meeting, the House of Delegates of the American Medical Association took action to support the inauguration by state boards of education or school districts, whichever is applicable, of a voluntary family life and sex education program at appropriate grade levels:

(1) as part of an overall health education program;

(2) presented in a manner commensurate with the maturation level of the students;

(3) following a professionally developed curriculum foreviewed by representative parents;

(4) including ample and continuing involvement of parents and other concerned members of the community;

(5) developed around a system of values defined and delineated by representative physicians, educators, clergymen, and members of other appropriate groups; and

(6) utilizing classroom teachers and other professionals who have an aptitude for working with young people and who have received special training.

The American Medical Association also recommended that local organizations be urged to utilize physicians as consultants, advisors, and resource persons in the development and guidance of such curricula, and that state and county medical associations be urged to take an active role in this participation.

As it has done in past years, the Iowa Medical Society aided in securing physician participants for health-education summer-school workshops designed especially for teachers at Drake University and at the University of Northern Iowa.

Representatives of the Society have appeared before study committees of the Iowa General Assembly to provide expert counseling on matters relating to sex education, drug abuse, accident prevention, etc.

The Committee is pleased to announce that the "Doctor's House Call" series of radio programs has been reinstituted over WOI, Ames. The Iowa Medical Society arranges for physicians from all parts of the State to be interviewed on various health subjects. "Doctor's House Call" is a weekly half-hour program and according to station officials it has a large audience and is very favorably received.

Attention of the delegates should be called to a very successful conference on drug abuse which was held in Des Moines last Fall under the sponsorship of the Iowa Health Council, of which the Iowa Medical Society is a member. The Society continues to assist in securing speakers for lay and professional groups and conferences, and on request it also provides various health education films and literature to physicians, schools, civic and service organizations, etc.

The Committee will continue to maintain close liaison with the State Department of Health with respect to the development and implementation of various health education programs.

C. E. ELLYSON, M.D., *Chairman*

NECROLOGY COMMITTEE

The following members of the Iowa Medical Society died during 1969:

	Age
N. Boyd Anderson, Springdale, Arkansas	75
George I. Armitage, Osceola	57
Henry A. Bender, Waterloo	75
Carl F. Brubaker, Corydon	78
George D. Callahan, Iowa City	62
Lawrence D. Colbert, Royal	54
Fern N. Cole, Iowa Falls	69
James O. Cromwell, Des Moines	64
Richard V. Daut, Davenport	50
Frank W. Fordyce, Des Moines	78
John H. Fraser, Monticello	80
George W. Gearhart, Springville	97
Amandus H. Grau, Denison	64
Bonnybel A. Hall, Maynard	77
Walker B. Henderson, Oelwein	62
Paul G. Ingham, Mapleton	79
Roy R. Jeffries, Waukon	78
Harry R. Jenkinson, Iowa City	79
Helen Johnston, Sun City, California	78
Roy K. Keech, Cedar Rapids	91
George H. Keeney, Los Angeles, California	89

John F. Kelly, Sioux City 53
Bernard E. Kenney, Council Bluffs 45
Harry F. Kiesling, Lehigh 79
Edward J. Liska, Ute 69
Julian E. McFarland, Ames 67
Caryl C. McIntyre, Waterloo 64
Melvin J. McVay, Lake City 86
Emery E. Magee, Cedar Falls 87
Howard L. Miller, Iowa City 59
Leo C. Nelson, Jefferson 68
Nelle S. Noble, Des Moines 91
Rusl P. Noble, Alta 63
Frank G. Ober, Burlington 66
Richard J. Peterson, Panora 42
Elwood P. Russell, Burlington 68
Verl A. Ruth, Des Moines 85
George H. Scanlon, Iowa City 74
John W. Schwartz, Sioux City 70
Clyde J. Smith, Gilmore City 47
W. Arnold Tice, Waterloo 55
Mary M. Troll, Cherokee 58
Howard V. Turner, Des Moines 59
Max F. Wetrich, Grand Junction 61
Loraine W. Ward, Oelwein 83
Ben T. Whitaker, Boone 82
Howard O. Young, Estherville 88

COMMITTEE ON LEGISLATION

As this report is written, the second sessions of the 63rd Iowa General Assembly and the 91st U. S. Congress are considering many health related items. On the state level, the Iowa Medical Society is keeping its membership informed on health items through LEGISLATIVE and NEWS BULLETINS.

In the U. S. Congress much attention has been devoted to the costs of Medicare and Medicaid, but no specific legislation has been seriously considered. Prior to the Annual Meeting, IMS officers will again travel to Washington, D. C., to meet with the Iowa Congressional Delegation.

It is still too early in the session, both state and nationally, to determine the outcome of legislation dealing with health. A comprehensive report on specific items of legislation will be presented to the House of Delegates as a Supplemental Report.

J. H. KELLEY, M.D., *Chairman*

SUBCOMMITTEE ON MEDICAL EXAMINER LAW

The Subcommittee has continued to work toward legislative approval of a bill to create a position of state medical examiner. During the first session of the 63rd Iowa General Assembly the Iowa Senate favorably considered a bill which was acceptable to the Iowa Medical Society but the House did not consider the bill.

In September, 1969, representatives of the subcommittee appeared at a legislative hearing regarding this matter. Also present at the meeting were officials of the Iowa Association of Pathologists and of the U. of I. College of Medicine, plus law enforcement representatives. The Society's position was presented, along with a proposed amendment making it clear that the state medical examiner shall be director of any laboratory.

Subsequent to the meeting the availability of certain federal funds, among other factors, has resulted in a proposal to establish a state crime lab in Des Moines for non-medical matters, and to create an office of state medical examiner in Iowa City who would operate out of the present medical laboratory facilities. A proposal to implement these possibilities has been reviewed by the IMS, and should be introduced in the Iowa General Assembly very soon. The proposal appears to be acceptable to the Iowa Medical Society.

The Subcommittee will continue to follow this legislation. A later report will no doubt be included as an item within the Supplemental Report of the Committee on Legislation.

G. R. CLARK, M.D., *Chairman*

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

At a meeting between members of the Committee on Medical Education and Hospitals and representatives of the University of Iowa College of Medicine early in January, it was announced that the faculty had voted to advise establishing a Department of Family Practice in the College of Medicine. This recommendation was subsequently approved by the Board of Regents. The committee will keep in contact with the College of Medicine as specific details with respect to the operation of the new department are developed.

The IMS has been provided information regarding two meetings held in Minneapolis during the past several months involving medical school deans, legislators, and medical society representatives from the states of Minnesota, North Dakota, South Dakota and Iowa. The meetings were arranged at the request of the State of North Dakota, and various items were included on the initial agenda—i.e., approaches to medical education and curricula to effect cooperation in medical education; affiliation of various medical schools; allocation of costs of medical education; tuition arrangements; admission procedures and transfer arrangements; etc. As a result of the first two meetings, a Four-State Coordinating Committee on Higher Education is to be created, and it is anticipated that representatives from the Iowa Legislature, the College of Medicine and the IMS will participate.

It should be noted that Richard Caplan, M.D., a College of Medicine faculty member who serves on the Committee, has been designated the director of medical education at the College, and one of his responsibilities is the developing and promoting of programs in continuing medical education. The IMS plans to cooperate with the College of Medicine to the fullest extent possible in this endeavor.

In an effort to gain some impression of the type of educational programs that are most desired by physicians throughout the state, a special booth on medical education will be set up in the exhibit section at Hotel Fort Des Moines during the Annual Meeting, and Dr. Caplan will be available to visit with physicians about their interest in and desires for continuing education programs. The Committee urges members of the House of Delegates to take the time to confer with Dr. Caplan about this important matter.

Your Committee chairman joined officers of the IMS in a meeting with the Executive Committee of the College of Medicine last summer to discuss various topics of mutual interest and concern, including

matters pertaining to the administrative organization and goals of the College of Medicine and the appointment of a new dean.

It should be stressed to the membership that there is a spirit of cooperation and common endeavor between the IMS and the College of Medicine that does not exist in all other states. This excellent liaison and rapport is maintained through contacts by officials of the Society, as well as by the Committee on Medical Education and Hospitals and the Task Force on Medical Manpower.

The Committee is represented by its chairman on the Task Force on Medical Manpower which, among other things, is devoting attention to the broad area of medical education as it pertains to increasing the supply of physicians for the state.

R. N. LARIMER, M.D., *Chairman*

COMMITTEE ON MEDICAL SERVICE

The report of the Committee on Medical Service customarily considers four areas of interest to the Society: (1) prepayment insurance mechanisms; (2) medical services to the indigent; (3) medical services for military veterans and their dependents; and (4) the inter-relations of hospital and medical service.

Previous reference has been made to the trend within the Society of having matters in these areas attended to by other committees and, in some instances, by the Board of Trustees. This pattern of referral to other committees has diminished the activity of the Committee on Medical Service.

In the area of prepayment insurance, it is appropriate to point out that the Society this year has maintained effective relations with Blue Shield and with various of the private insurance companies. A joint meeting of the Executive Committee of the Blue Shield Board of Directors and the Society's Board of Trustees is scheduled March 19 and items considered at that time will presumably be reported to the 1970 House of Delegates.

It should be acknowledged that Blue Shield has continued to comply with the request of the House of Delegates that increased coverage be provided for out-of-hospital services. New coverages in this area were set forth in some detail when the House of Delegates last met. Efforts to market this coverage continue. In a further attempt to fulfill the askings of the House, Society and Blue Shield representatives have discussed, on a preliminary basis, ways in which coverage for outpatient mental health care might be increased.

The involvement of Blue Shield as Iowa carrier for the major governmental (Medicare and Medicaid) programs has placed it in a position to receive periodic criticism from physicians. It should be noted that the governmental carriers are required to adhere to applicable federal regulations. Some of these federal edicts are arbitrary and inequitable from the Society point of view; nonetheless, Blue Shield as carrier is required to observe the rulings.

The Subcommittee on Public Assistance has maintained liaison for the Society with the State Department of Social Services insofar as Title XIX is concerned. Meeting jointly with the Committee on Economics of Health Care, the Public Assistance Committee initiated that activity this year which has led to the development of an expanded and important peer review system. Established on a district basis, this enlarged peer review program is available to any third party with a question about the delivery of a medical service.

The Society is continuing to function as fiscal agent for the U. S. Department of Defense in the administration of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). On January 1, 1969 certain of the claims-processing chores were transferred from Wisconsin Physicians' Service to Iowa Medical Service (Blue Shield) in Des Moines.

During the calendar year 1968, the number of CHAMPUS claims processed by the Society totalled 8,223. The amount of money paid in 1969 was $564,-548.10. These figures are quite comparable to those recorded in 1968. They are substantially greater than 1967 when the CHAMPUS program was broadened.

Reports from Iowa VA officials indicate the Veterans' Hometown Care Program is operating satisfactorily. Veterans residing within close proximity (30 to 40 miles) of a Veterans Hospital must obtain care for service-connected disabilities at this government facility. Apparently there is some latitude in the application of this ruling when a hardship is involved. Iowa physicians have been encouraged by the VA to ask the veteran for his identification card so as to determine the covered disabilities and the extent of coverage. Also, doctors have been asked to remind those patients on the VA aid and attendant program they must have their prescriptions filled by a VA pharmacy. While payment for services rendered under the VA program is derived from a fee schedule, effort is made to pay usual and customary fees whenever possible.

Throughout the year the Society has received inquiries from member physicians and others regarding the delivery of medical service. Effort has been made to answer the questions and concerns as promptly as possible. The Society has continued to make available the IMS Attending Physician's Statements to physicians requesting them. It has also called attention to the availability of the standard claim form of the Health Insurance Council.

It is expected that one of the Society's officers will participate in the AMA's Fourth National Congress on the Socio-economics of Health Care to be held in Chicago March 20 and 21. The theme of this meeting is: Systems of Health Care Delivery: Appraisals and Projections.

J. K. MACGREGOR, M.D., *Chairman*

SUBCOMMITTEE ON HOME HEALTH SERVICES

The Iowa Medical Society continues to be represented on the State Council for Homemaker Services by the chairman of this Subcommittee. The Council was formally created in 1968, and functions as a data gathering and disseminating body for the steadily increasing number of local and county agencies which provide care of this nature.

A brief recapitulation of the rapid growth of home health programs in Iowa may be of interest to the members of the House of Delegates. In 1966 there were 15 Medicare-certified home health agencies providing services to 41 per cent of the Iowa population. As of November 1, 1969, there were 37 such certified agencies serving 57 per cent of the state. It is estimated that 75 per cent or more of the home care services are provided to the elderly. Studies show that during the first quarter of 1966, less than 30,000 hours of homemaker-

health aide service was provided in the state; by contrast, in the second quarter of 1969 more than 100,000 hours of such service was delivered.

For your further interest and information, there are now in Iowa 18 visiting-nurse associations, and 59 counties have one or more public health nurses.

As in all other segments of the health care system, physicians play an important part in organizing and delivering home health services. Physicians serve on the governing boards of home health agencies, whether private or public. They have a part in determining agency policies and evaluating performance. Physicians order plans of treatment for patients who receive home health service, and they follow the service to make certain it is provided and that it continues to be medically necessary. These factors are set forth merely to emphasize the important responsibilities of physicians in this area.

For more detailed information on the development of home health services in Iowa, the attention of the House of Delegates is directed to the November and December, 1969, and February, 1970, issues of the JOURNAL OF THE IOWA MEDICAL SOCIETY. The State Department of Health sections in each of these JOURNALS discusses this subject.

J. F. VEVERKA, M.D., *Chairman*

SUBCOMMITTEE ON MEDICAL PRACTICE IN HOSPITALS AND NURSING HOMES

In its 1969 HANDBOOK report this Subcommittee presented data to illustrate the growth of hospital and nursing home facilities in Iowa. This summary dramatized the growth of such facilities which occurred during the decade of the 1960's and which is continuing into the 1970's.

In this report it should be noted that the Society has been able to maintain a good working relationship with both the Iowa Hospital Association and the Iowa Nursing Home Association this year. There continues to be many complex Medicaid and Medicare matters of particular concern to hospitals and nursing homes, but which also effect physicians. These include utilization review, determination of charges, minimum wage requirements, acquisition and retention of personnel, planning and expansion, etc.

A federal requirement that nursing home administrators be licensed by the state still must be implemented in Iowa. Legislation to accomplish this has been drafted and is now receiving consideration by the Iowa General Assembly.

Also, as mentioned in the report of the Subcommittee on Aging and Chronic Illness, consideration is now being given to a legislative proposal which establishes new nursing home standards for licensure purposes. This bill categorizes these facilities into one of six or seven classifications. The bill is now being reviewed by the Society.

In compliance with a request of the 1969 IMS House of Delegates, the Society this year has endeavored to provide member physicians informational material on the differentiation in the Medicare and Medicaid regulations between medical care and custodial care as it is provided in extended care facilities. The Society has distributed two News Bulletins on the subject and it has been in ongoing communication with the carrier on other means of informing Iowa physicians.

There has been considerable recent comment in the news media about actions taken by nursing home interests in the state to dramatize the fiscal problems they say they are confronting. In December at a meeting of nursing and custodial home administrators an action was taken to suspend the admission of welfare recipients in nursing and custodial homes effective January 31, 1970; this move was reportedly to remain in effect until welfare payments are increased. The degree to which the action has been implemented is not known.

MEDICO-LEGAL COMMITTEE

No matters have been referred to the Committee during the current year; therefore no meetings have been scheduled.

The attention of the House of Delegates is directed to the report of the Iowa Bar Liaison Committee, where reference is made to the Society's interest in and concern over malpractice coverage for physicians. As is mentioned in that report, the Society this year has had the benefit of an authoritative assessment of national malpractice trends. This evaluation was made by Mr. Bernard Hirsh, director of the AMA Law Division, in an appearance before the IMS Executive Council. Mr. Hirsh counseled the Society not to experiment with new programs at this time.

The Society has been in contact this year with representatives of the insurance companies which provide the bulk of the professional-liability coverage to Iowa physicians. These representatives acknowledge some substantial increases in premiums, but in doing so they point out that the Midwest still remains in a decidedly more favorable situation than either of the Coasts with respect to professional-liability coverage. The Society has recently become aware of a new group-liability program which is being undertaken by the Nebraska Medical Association. Further evaluation will be made of this program.

A. L. JENKS, JR., M.D., *Chairman*

PUBLIC RELATIONS COMMITTEE

The Committee on Public Relations met in joint session with representatives of the Society's Committee on Quackery and Committee on Legislation to consider short-range and long-range activities of the IMS to gain public support of medicine's position on various health matters and understanding on health care delivery problems.

The IMS has been involved in various P/R type programs designed to improve medicine's image with the public. As a matter of fact, most all of the projects implemented by the Society have a direct or indirect P/R impact, and are carried out in the public interest. In this regard, the Committee wishes to focus attention on the following:

- The efforts of the Task Force on Medical Manpower in studying ways and means of improving and assuring the delivery of health-care services to all in need have been favorably received. Of special significance was the series of meetings on problems relating to health-care delivery held last fall under the sponsorship of the IMS, the U. of I. College of Medicine and the Health Planning Council of Iowa, involving both professional and community leaders.
- The Iowa Health Council, of which the IMS is a member, sponsored an outstanding Conference on Drug Abuse on October 8. Arrangements and publicity

were coordinated through the Society's headquarters office. The favorable response to the program has been overwhelming, and it is likely that additional conferences will be held in the future on other subjects of major interest and concern.

- The IMS continues to serve as a co-sponsor of the Hawkeye Science Fair, along with the DES MOINES REGISTER AND TRIBUNE, Drake University, and the Scanlon Medical Foundation/IMS. The 12th Hawkeye Science Fair will be held in Des Moines on April 10-11. The top winner at the 1969 Hawkeye Fair also received top honors at the International Science Fair, and was awarded a trip to Japan.
- The IMS coordinates arrangements for the Hall of Health exhibit section at the Iowa State Fair. The project is sponsored by the Iowa Health Council, and over 20 exhibits were displayed at last year's event.
- The IMS works closely with WOI Radio and WOI Television in Ames in arranging programs on health subjects. The "Doctor's House Call" radio series has been revived after a two-year layoff. Physicians from various parts of the state appear on the program to answer questions and discuss important health topics. Representatives of the Society have also appeared on three programs in the "Dimension V" television series. Subjects discussed were "Drug Abuse," "Organ Transplants" and "Medical Manpower." The program is telecast live, and has gained a large audience in the central Iowa region.
- Reprints of the "In the Public Interest Section" of the IMS JOURNAL are mailed regularly to all news outlets in the state, as well as to all Iowa legislators. The subjects covered during the past year included drug abuse, peer review, medical manpower, immunization programs and Medicare/Medicaid.
- Liaison is maintained with the local press, radio and television outlets and with the wire services. Personal contacts are made with representatives of the press whenever there is an opportunity to provide information on IMS problems and projects, and increasing efforts have been made to respond to articles which may not accurately reflect the Society's position or involvement in matters relating to health.
- A prime effort of the IMS during the past several months has been to assure the public that, as has been traditionally true, the medical profession will take all steps necessary to protect against any intentional or unintentional abuse associated with the delivery of health care. In this regard, major emphasis has been placed on the peer-review mechanism.
- Press coverage of the Society's Annual Meeting is excellent, and every effort is made to capitalize on this opportunity for informing the public on programs and positions of organized medicine.

JOHN G. THOMSEN, M.D., *Chairman*

SUBCOMMITTEE ON INTERPROFESSIONAL ACTIVITIES

Two members of the Subcommittee on Interprofessional Activities—S. P. Leinbach, M.D. and C. E. Radcliffe, M.D.—and the executive vice-president of the Iowa Medical Society, Mr. Donald L. Taylor, represent the Society on the Board of Directors of the Iowa Health Council.

Since its recent reorganization, the Iowa Health Council has expanded its original membership (IMS, Iowa Dental Association, Iowa Pharmaceutical Association, Iowa Veterinary Medical Association, Iowa Hospital Association and Iowa Nurses' Association) by adding the Iowa Society of Osteopathic Physicians and Surgeons and the Iowa Nursing Home Association. An application from the Iowa Podiatry Society is pending, and it is anticipated that other qualified groups will be considered in the future.

A very successful statewide Conference on Drug Abuse was sponsored by the IHC on October 8, 1969 in Des Moines. Arrangements were coordinated through the IMS headquarters office. More than 1,700 persons—including students, teachers, law enforcement officials, etc.—attended and the response has been gratifying. A follow-up questionnaire completed by a selected number of conferees indicates that as a direct result of the conference, many schools and communities have conducted additional programs on drug abuse.

Thousands of informational pamphlets and brochures on drug abuse, as well as a resource list of available materials, were distributed at the state conference, and are being mailed to other interested persons on request.

It is anticipated that the IHC will sponsor similar programs in the future.

A dinner honoring members of the 63rd Iowa General Assembly was sponsored by the IHC on January 28, 1970 in Des Moines. Although there was no formal program, the legislators were apprised of the purposes and objectives of the IHC, as well as some of its educational projects.

The Council continues its sponsorship and coordination of the Hall of Health exhibit section at the Iowa State Fair. Several thousand persons visit the special health section to see the many exhibits displayed by the member organizations and other health-oriented groups.

As has been its custom, the IMS Committee on Interprofessional Activities met recently with a similar committee of the Iowa Pharmaceutical Association to consider items of mutual interest and concern. Primary attention was given to two subjects.

First, the authority of podiatrists to prescribe drugs for their patients was discussed. It was acknowledged that there are points in the law regarding the scope of podiatry which need clarification, and these will be carefully studied so that any problems with respect to the prescribing of drugs by podiatrists can be avoided.

Second, the committees reviewed in detail the provisions of the Uniform Narcotics Drug Act. There will be continued discussion of this subject at future joint meetings, especially in regard to the application of the law to pharmacists and physicians.

As was reported to the House last April, the IMS challenged an opinion issued by the Iowa Attorney-General on April 1, 1968, that "medical practitioners are authorized to prescribe, administer and dispense prescription drugs, but nurses or aides can only administer such drugs, and then only under the direction of a medical practitioner." The Committee is pleased to announce that the Society has been informed that the Attorney-General plans to issue a new opinion which, in effect, will supercede the previous one and provide that nurses and aides may dispense all drugs other than narcotics, under the direction or supervision of a physician.

C. E. RADCLIFFE, M.D., *Chairman*

COMMITTEE ON STATE DEPARTMENTS

As has been customarily pointed out in this brief report, the Committee on State Departments serves an umbrella function for six subcommittees which have liaison relationship with various agencies of state government. The chairmen of these six subcommittees (Aging & Chronic Illness, Maternal and Child Health, Psychiatric Care, Public Assistance, Rehabilitation and Safe Transportation) comprise the Committee on State Departments.

Members of the House of Delegates are invited to review the separate reports of the several committees. In practically all cases, the committees have been active during the 1969-70 year. For example, the Maternal and Child Health Subcommittee has been cooperating with the Department of Health in the current statewide rubella-eradication program; the Public Assistance Subcommittee has conferred with representatives of the State Department of Social Services on Title XIX matters, and the Subcommittee on Psychiatric Care has been in contact with the Iowa Commission on Alcoholism with respect to a project.

Because the Society does have a keen interest in matters pertaining to public health, it is appropriate to mention the valuable service provided by the three IMS member physicians who serve on the State Board of Health. These men are F. H. Top, M.D., E. E. Gamet, M.D., and P. J. Leehey, M.D. In continuing an established practice, the IMS JOURNAL publishes bulletins and special articles on public health matters which the Department of Health wishes to bring to the attention of Iowa physicians. The Society also receives and distributes a monthly summary of Health Department activities to the appropriate IMS representatives.

It is desirable in this report to note the recent appointment of Arnold M. Reeve, M.D., to succeed James F. Speers, M.D., as Commissioner of Health for the State of Iowa. Dr. Reeve returns to Iowa after a short term as the Nebraska Health Commissioner. Dr. Reeve has met already with Society officers to establish communications and set up working procedures between the Department and the IMS.

The Society this year responded favorably to an inquiry from the American Medical Association regarding the merits of a conference for physicians on environmental and public health matters. Such a conference presumably would deal with air, water and soil pollution, communicable diseases, and public health problems related to urban populations.

I am pleased to serve as chairman of this parent Committee and to offer these remarks as an introduction to the subcommittee reports which follow.

A. H. DOWNING, M.D., *Chairman*

SUBCOMMITTEE ON AGING AND CHRONIC ILLNESS

The Subcommittee on Aging and Chronic Illness conferred in October with James F. Speers, M.D., then Iowa Commissioner of Public Health. This meeting was for the principal purpose of discussing matters relating to the operation of nursing homes in the state.

Dr. Speers told the Subcommittee the Health Department has decided to suspend its efforts to revise those rules and regulations which cover the operation of nursing and custodial homes in Iowa. Dr. Speers said the Department instead plans to seek a completely new state law establishing nursing-home standards.

The Subcommittee was informed that currently the Department of Health conducts inspections of nursing homes, and that the Department of Social Services assumes responsibility for inspections of custodial homes. The actual licensing of both types of facilities is handled administratively by the Health Department. The Subcommittee was told that existing licensing mechanisms are inadequate and that Department efforts to correct them by adding new rules and regulations have proved ineffective.

The legislative proposal contemplated by the Department of Health, according to Dr. Speers, would increase the number of classifications for homes from two (nursing and custodial) to perhaps six. The classifications would presumably aid the public in determining the extent and quality of care available in a particular facility. Dr. Speers said he would forward the Department's bill to the Society for review and reaction by the Subcommittee.

The Subcommittee was told additionally that the Iowa Nursing Home Association also supports some revised-classification approach. It was pointed out that the INHA in recent years has been actively engaged in attempts to upgrade the state's nursing homes.

To date, no legislative proposal has been forwarded to Society by the Department of Health. However, the Society has just acquired a legislative proposal which follows the multi-classification approach advocated by the Department of Health. This bill (H.F. 1243) has been introduced in the House of Representatives. It has been presented by the Committee on Social Services of the House. Society officers are now in the process of reviewing the proposal and copies are also being circulated to the members of the Subcommittee for review and reaction.

The Subcommittee has been briefed on a one-day hearing conducted in Des Moines last fall by the U. S. Senate Special Committee on Aging. Among the statistics presented at this hearing were (1) one-third of the older Americans live in or near the poverty level; (2) Iowa is second only to Florida in percentage of people over 65; (3) 66 per cent of those over 65 who live alone have less than $2,000 annual income, and (4) of the 318,000 persons over 65 in Iowa, 67,000 hold either part-time or full-time jobs.

The Subcommittee was informed that the Aging and Chronic Illness Division of the Department of Health utilizes its funds in three principal areas: (1) in the homemaker-health aide area, (2) to support stroke rehabilitation, and (3) to assist in an anti-smoking education program.

G. E. MONTGOMERY, M.D., *Chairman*

SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

This year the Subcommittee on Maternal and Child Health has devoted itself primarily to activities relating to the administration of the new rubella vaccine. The Subcommittee has conferred at some length with officials of the State Department of Health on this subject.

For background purposes the House of Delegates is reminded that the first rubella vaccine was licensed in mid-1969, somewhat earlier than many had anticipated. This licensure of the vaccine came admittedly

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before detailed plans covering its use were completed either at the federal or state levels.

Because of the cyclic nature of the disease and because of anticipated epidemic during the 1970-71 school year, the State Department of Health immediately expressed a desire to undertake an extensive immunization campaign. Department officials advised the Subcommittee it would be highly desirable to immunize as many children (ages 1-12) as possible prior to the expected epidemic. Such a broad program would seek to eradicate the reservoir of rubella in order to protect pregnant mothers from the possible untoward effect it could have on their offspring.

At a meeting on November 20, 1969, the Subcommittee recorded itself as in strong support of the efforts of the Department of Health to coordinate a statewide rubella eradication program. Approved by the Subcommittee at that time was a statement regarding rubella subsequently released by Society President W. M. Krigsten, M.D. This statement summarized the advances in preventive medicine and referred to the rubella vaccine as another medical breakthrough. It explained that widespread use of the vaccine would eradicate the generally mild disease and, more importantly, that it would eliminate the serious manifestation it produces in pregnant women. Reference was made in the statement to the testing of the vaccine which preceded its licensure.

The statement told of the desire of the Department of Health to coordinate mass immunization clinics in as many Iowa counties as possible prior to the close of the 1969-70 school year. In amplification of this expression the following comments were included:

> "Support for this increased immunization activity has come from the Iowa Chapter of the American Academy of Pediatrics and from the Committee on Maternal and Child Health of the Iowa Medical Society. Under the existing policy of the Iowa Medical Society, the conduct of a mass immunization program is permissible provided that it has the approval of the concerned county medical society. It is the belief of the Iowa Medical Society that local physicians, working within the framework of a county society, are most qualified to determine the best methods of providing preventive, diagnostic and therapeutic health care. County societies recognize they have a responsibility to assure that, to the fullest extent possible, such preventive health measures as immunizations are provided to the highest feasible percentage of the population. The manner in which this is done should be determined by local physicians."

The Subcommittee has volunteered to provide its counsel and expertise, as it may be desired, to the Department of Health and to individual county medical societies as they consider and conduct rubella programs. As this report is prepared, all but two county societies have advised the Department they wish to offer some type of a cooperative rubella immunization program. The Department of Health reported as of February 16 that approximately 140,000 of the estimated 600,000 Iowa youngsters between one and 12 years of age had been vaccinated. County programs at this time have been scheduled into April and May.

The House is aware of the considerable attention which has been given to the rubella campaign by the news media. The reports have noted that various sources of financing, both state and local and public and private, have been and are being utilized to purchase vaccine. The Scanlon Medical Foundation/Iowa Medical Society is cooperating in the financing process to the extent of serving as a repository for private funds contributed by schools, individuals, etc.

The Subcommittee is gratified by the rapid action which has been taken by the county medical societies in approving and scheduling mass rubella programs.

Also in the immunization area, the Subcommittee has been advised by the Department of Health that it has now assisted with mass programs for red measles in approximately 80 Iowa counties. Efforts here have been suspended while attention is directed at rubella.

The subject of therapeutic abortion has been considered by the Subcommittee regularly during the past several years. Recommendations devised by the Subcommittee in 1968 are the basis for the current position of the Society with respect to the liberalization of Iowa's statutes.

A new recommendation or approach has now been referred to the Subcommittee for evaluation prior to the 1970 Annual Meeting. This recommendation emanates from the Subcommittee on Psychiatric Care and states simply that a therapeutic abortion should be strictly a matter to be resolved between the patient (and her spouse) and her physician. This idea is also embodied in a legislative proposal which has been introduced in the Iowa General Assembly by State Senator Charlene Conklin.

The Subcommittee on Maternal and Child Health expects to consider these and other items relating to therapeutic abortion at a meeting on March 4. The House of Delegates will be provided a supplemental report on the recommendations which come from this meeting.

In other action this year the Subcommittee (1) recommended the Society become affiliated with the Nutrition Council of Iowa, (2) endorsed the Society's continuing to sponsor the Iowa Youthpower Project, and (3) discussed the OEO-Department of Social Services Supplemental Food Program.

W. J. BALZER, M.D., *Chairman*

SUBCOMMITTEE ON PSYCHIATRIC CARE

The Subcommittee on Psychiatric Care has met three times during the 1969-70 year and is scheduled to confer again on March 18. Its activities have covered a broad spectrum.

On November 13 the Subcommittee met with new State Social Services Commissioner, James Gillman. In this meeting the full range of mental-health and mental-retardation services provided by the State Department of Social Services received attention. Of particular interest and concern to the Subcommittee is the matter of a successor for James O. Cromwell, M.D., who served as Director of the Bureau of Mental Health until his death in 1969. Commissioner Gillman indicated he plans to move deliberately in search of a replacement for Dr. Cromwell. He accepted the Subcommittee's offer of assistance in locating a qualified person for this post.

The Subcommittee visited the new James O. Cromwell Children's Unit at the State Mental Health Institute in Independence on January 15, 1970. In ad-

dition to touring these facilities, the Subcommittee held a regular meeting. Consideration was given at this session, as it has been at earlier meetings, to several pieces of mental-health legislation which are now before the Iowa General Assembly. Two bills in particular, in the House of Representatives, have been followed by the Subcommittee. One allows a county or group of counties to set up a broad mental-health program with a permanent state appropriation available to aid in supporting the program. This program would allow the county or counties to contract for services with a state institution, a local public or private hospital, private practitioners or a community mental health center. The second bill would combine the present county fund for mental health with the state-institutions fund, and would give it the following new designation: "the county health and institutions fund." From this fund the county boards of supervisors would pay for a variety of mental-health services provided to eligible residents.

The Subcommittee devoted considerable time on January 15 to the subject of therapeutic abortion. Its review was precipitated (1) by a recent survey made by the Iowa Psychiatric Society, and (2) by new legislation introduced by State Senator Charlene Conklin. In the IPS survey 77 per cent of its member psychiatrists responded affirmatively to the question: "Should we endorse or sponsor legislation to legalize abortion, so that a licensed physician be permitted to perform one when in his opinion and clinical judgment it is indicated?" It was noted the Conklin proposal corresponds to a substantial degree with the feeling represented by the majority response to the survey question.

The Subcommittee reviewed the current position of the Society which the House of Delegates established in 1968 and reaffirmed in 1969. This position supports liberalization of the long-standing state abortion statutes if certain guidelines are followed. Recognizing the existing Society policy and also recognizing the sensitivity of this subject, the Subcommittee nonetheless unanimously approved a motion which declared that therapeutic abortion should be strictly a matter to be resolved between the patient (and her spouse) and her physician. This action of the Subcommittee was reported to the IMS Executive Council in January. The Subcommittee's report was received by the Council, and referred to the Subcommittee on Maternal and Child Health for study and report. It is presumed that this Subcommittee will make some comment on the subject to the 1970 House of Delegates.

The Subcommittee has been distressed over developments associated with the staffing of the new Iowa Security Medical Facility at Oakdale. With the recent resignation of Douglas Johnson, M.D., from the staff of the Facility, it is understood there is now no resident medical coverage. The Subcommittee has lamented the fact that the Facility is headed by a person with corrections experience instead of a medical background.

The Subcommittee has been involved this year in the preliminary stages of a comprehensive study of Iowa's commitment laws. In its consideration of this subject, the Subcommittee has been in communication with the Iowa Bar Association's Special Committee on the Law and Behavioral Sciences. This evaluation will draw heavily upon the information and recommendations included in the "Iowa Civil Commitment Study" which is scheduled to appear in the IOWA LAW REVIEW within the near future. The Subcommittee has had an opportunity to make a preliminary and cursory review of the recommendations contained in this Study and it has expressed some reservations as to the regressive nature of the proposed alterations in the commitment process. The Subcommittee acknowledges that this is an area which has been discussed for many years, and it concurs that it is one which needs continued careful study. The Subcommittee expects to evaluate this new "Civil Commitment Study" further, and will support or oppose its recommendations for changes in the existing statutes.

In other activity, the Subcommittee is seeking to establish an IMS Subcommittee on Alcoholism; S. M. Haugland, M.D., and L. E. Sedlacek, M.D., are providing leadership in this effort. The Society and its Subcommittee on Psychiatric Care have been represented by the chairman at a meeting on drug abuse called by the governor of Iowa. The Subcommittee has designated two of its members to meet with Blue Shield officials to discuss trends in mental health coverage and to determine the prospects for increased outpatient coverage. The Subcommittee expects to be represented at the 16th Annual AMA Conference for State Mental Health Representatives to be held March 13 and 14 in Chicago. The Subcommittee has had opportunity to assist the 1970 Annual Meeting Program Committee in the planning of a session on psychiatric emergencies.

The Subcommittee was saddened this year over the death of one of its veteran members, W. A. Tice, M.D., of Waterloo.

W. A. BOCKOVEN, M.D., *Chairman*

SUBCOMMITTEE ON PUBLIC ASSISTANCE

During 1969-70 the Subcommittee on Public Assistance has sought to keep open its lines of communications with the State Department of Social Services (SDSS) on matters pertaining to the Iowa Medical Assistance Program (Title XIX/Medicaid). This report summarizes the meetings of the Subcommittee on Public Assistance and the Medical Assistance (Title XIX) Advisory Council.

The Subcommittee contributed, in some measure this year, to a broadening of the Society's Peer Review Program. Meeting jointly with the Committee on Economics of Health Care on May 22, 1969, the Subcommittee helped formulate recommendations which were instrumental in initiating the Society's new District Peer Review Program. For a summary of those recommendations, the House of Delegates is referred to the report of the Committee on Economics of Health Care.

The Iowa Title XIX program has received much attention from the mass media during 1969-70. The federally-directed restrictive reimbursement policies, the strong allegations of vendor abuse and other factors have brought a period of not unexpected confusion and frustration. The Society has voiced its concern over these developments to HEW Secretary Robert Finch, to representatives of the State Department of Social Services, to the IMS membership and to the general public through the news media.

According to the most recent information provided the Subcommittee, Title XIX spending is averaging

1.9 million dollars per month. About 2.1 million dollars is available per month from the 26.4 million current annual appropriation. Increased participation by medically indigent individuals in the OAA and ADC groups is placing a strain on the funds available.

Various federal Title XIX regulations await state implementation. One of these calls for a formal agreement between the State Department of Social Services and the providers of service. The agreement states that the provider must maintain and make available fiscal and clinical records sufficient to support and justify Title XIX charges. It should be emphasized that this is a federal regulation which the SDSS is required to implement at some point.

The House of Delegates is aware that the present Medicaid (like the Medicare) freeze on physicians' fees will remain in effect on its present basis at least until July 1, 1970. In Iowa, for some time, Medicaid and Medicare payments have been pegged at the 83rd percentile of the range of customary charges. The real inequity here is that the customary payment levels in use have been determined on the basis of physicians' charges submitted in 1968. As are most Iowa physicians, the Subcommittee is concerned about the ability of the doctor to maintain a fiscally sound medical practice in an inflationary period with this kind of restriction.

Other new federal Medicaid rules which have been outlined by the SDSS include (1) a regulation that postpones from 1975 to 1977 the deadline for making Title XIX programs comprehensive in (a) medical services and (b) population groups covered, and (2) a ruling which allows a state to provide only the five basic services (inpatient hospital, outpatient hospital, physician services, skilled nursing home care and other diagnostic and x-ray services). Under this condition, however, state appropriations must be kept at least equivalent to those which were allocated in pre-Title XIX programs. Iowa had a relatively comprehensive program prior to the advent of Title XIX, and no serious consideration has been given to the reduction of any services. Even so, the SDSS does now have the authority to reduce services; for example, action could be taken to eliminate drugs and dental services. The House may recall that an action was taken a year ago which curtailed the number of participants in the program and limited the number of days of hospitalization.

Reference should be made in this report to the fact that utilization review for physicians is being undertaken initially as part of the carrier's Quality Assurance Program (QAP). QAP was made applicable to physician services under Title XIX in 1969 in an action taken by the SDSS. Various QAP parameters identify possible over-utilization, excessive services or other abuses. The carrier's claims examiners and medical staff apply the QAP parameters to incoming claims. If determination of payment is not possible at this point, the claim is referred to the SDSS, and if further consultation appears necessary, the services of the IMS District Peer Review Program are requested.

One particular concern of the SDSS has been the high level of expenditures in the pharmaceutical area. Pharmaceutical parameters have been established for use in reviewing drug claims, and the SDSS is making audits of pharmacies. The Subcommittee has again joined with the SDSS in encouraging physicians to prescribe a 30-day medication supply or a packaged unit whenever possible. This recommendation has been transmitted to IMS members through the NEWS BULLETIN, the IMS REPORT, and the IMS JOURNAL, as well as through a mailing from the SDSS.

The Subcommittee has been kept informed regarding activities of the Society's Title XIX Peer Review. It is understood that henceforth reviews will differ from the one conducted, this past year, of the 14 physicians whose Medicaid payments had been at a high level. With the QAP in effect under Title XIX, reviews will now be more on a day-to-day or week-to-week basis, and there will be no need for an evaluation covering any long period of practice. It is the understanding of the Subcommittee that 6 of the 14 physicians who were reviewed in depth this past year have been placed on probationary status and will be kept under close scrutiny by the carrier. The SDSS has indicated that two of the cases warranted evaluation in terms of possible immediate suspension and possible prosecution for fraud. This consideration is apparently in process.

The Medicaid Study Committee of the Iowa General Assembly has conducted an extensive review of the program this year. One of the recommendations of this Committee concerns the peer review process and calls for including a legislator on a review committee either as an actual member or as an observer. In January the IMS Executive Council reaffirmed the Society's position that peer review should be a function of the medical profession and should not involve lay persons. This action does not preclude meetings between legislators and Society representatives to discuss the program and to assure an understanding of how it works.

Other Title XIX items which have been considered by the Subcommittee include (1) the confirmed over-utilization or abuse of the program by the recipients of care; (2) the new two-card identification eligibility system; (3) the approval of a new and more comprehensive contract between the SDSS and the carrier which allows the carrier $1.19 per claim; (4) the recent federal court ruling (Dimery Case) which held that the SDSS exceeded legal bounds in making eligibility determinations (Legislation is now being considered by the General Assembly to clarify this situation); (5) the administrative economy measure now being encouraged which calls for the submission of only one claim per month listing, if necessary, several services; and (6) the questionable merits of involving vendors in the eligibility-determination process.

Other matters discussed by the Title XIX Advisory Council, in addition to many of the preceding, have included (1) the legality of payments to vendors outside the state; (2) the degree of responsibility which vendors have for reporting information concerning possible ineligibility of recipients; (3) the merits of a prepaid insurance coverage for Title XIX recipients with the premiums paid from Medicaid-appropriated funds.

In further reference to recommendations of the Medicaid Legislative Study Committee, the desire has been expressed to add four lay persons to the Title XIX Advisory Council; there now is one lay person on the Council. Also, the Study Committee is suggesting that the 1970 General Assembly change the language regarding the use of an independent carrier from "shall" to "may." This is likely to be considered favorably by the legislature.

In concluding this informal report, let me remind you that the IMS approached Title XIX believing it would be a program to provide care for those in need. When the program was initiated, the IMS felt the program should embody at least four basic prin-

ciples: (1) payment of usual, customary and reasonable charges, (2) freedom of choice for recipients of care, (3) professional freedom for practitioners, and (4) use of a private fiscal intermediary. The House may wish to judge how these principles have been eroded during the nearly three years of the program.

L. J. O'BRIEN, M.D., *Chairman*

SUBCOMMITTEE ON REHABILITATION

The lines of communication between the Society and the Division of Rehabilitation Education and Services of the State Department of Public Instruction have remained open this past year. The presence of Homer E. Wichern, M.D., as chief medical consultant for the Division is valuable in maintaining this open exchange of information. Dr. Wichern has occasion to be in periodic contact with many Iowa physicians in his consulting capacity.

It might be noted that a summary of the extensive report entitled Comprehensive Statewide Planning for Vocational Rehabilitation Services was completed in 1969 and has since been made available to the members of the Committee. The following short quotation from it is perhaps significant: "Task forces found a widespread lack of understanding of the rehabilitation function and its component services. They repeatedly asked that ways be found to increase the comprehension of persons—including family doctors and school personnel—whose attitudes determine the progress of the handicapped."

Among the summary recommendations accompanying this comment are these:

- That orientation and continual updating of personnel in pediatrics, general medicine and education be among the prime targets of public information efforts by rehabilitation agencies.
- Medical schools in Iowa consider teaching more subject matter related to vocational rehabilitation as well as medical rehabilitation.
- Doctors be invited to observe vocational rehabilitation techniques and facilities, and to participate more fully in related activities.
- Medical consultants of rehabilitation agencies and other professional staff take an active part in programs sponsored by medical associations in the state.

The extent of the effort which has been put forth thus far to implement these recommendations is not known.

Reference might be made at this point to the appointment this year of a new Society committee which is to concern itself with certain aspects of the rehabilitation process. This committee has been designated as the Committee on Employment of the Handicapped. It has met several times during the 1969-70 year, and has had occasion to discuss with representatives of several of the rehabilitative agencies various programs which are operative in Iowa. It is understood the Committee will confer on March 4 with a representative from the faculty at the University of Iowa College of Medicine about the second recommendation noted in the preceding reference to the Statewide Planning Report.

In its deliberations in recent years, the Subcommittee on Rehabilitation has had occasion to consider and develop recommendations similar to those which have been assembled by the Committee on Employment of the Handicapped and approved by the IMS Executive Council. Particular emphasis might be given to (1) the recommendation which suggests that the Division of Rehabilitation Education and Services devise an information "feed-back" program for physicians as a means of securing greater physician participation and cooperation, and (2) the recommendation that there be a refinement of the forms which are used in the Vocational Rehabilitation and Social Security programs in gathering information from physicians. Your attention is directed to the HANDBOOK report of the Committee on Employment of the Handicapped for a complete listing of these recommendations.

The presence of Dr. Wichern on both Society committees (Rehabilitation and Employment of the Handicapped) will allow for a flow of communication between the two. This is desirable.

C. B. LARSON, M.D., *Chairman*

SUBCOMMITTEE ON SAFE TRANSPORTATION

Last April, on recommendation of the Subcommittee on Safe Transportation, the Executive Council of the Iowa Medical Society approved a "Statement of Basic Principles and Recommendations" relating to ambulance services and facilities as guidelines for developing legislation pertaining to the organization and operation of ambulance services. The original statement was developed by an *ad hoc* committee of the Iowa Hospital Association, but the IMS Subcommittee on Safe Transportation had an opportunity to review and offer specific suggestions regarding its contents. Appropriate information on this subject has been provided to the Iowa Medical Society's Committee on Legislation.

The Iowa Medical Society continues to cooperate with the State Department of Health, the University of Iowa College of Medicine, and the Trauma Committee of the American College of Surgeons in sponsoring area conferences on "The Immediate Care of the Sick and Injured." Appropriate county medical societies cooperate in this endeavor. The courses are designed for ambulance drivers, policemen, firemen, etc. One session was held at Des Moines June 23-24, and another in Sioux City September 25-26.

The Medical Advisory Board which was created by the Iowa Medical Society in 1966 to assist the State Department of Public Safety in evaluating the medical reports regarding certain applicants for drivers' licenses continues to function. To date, the Advisory Board has evaluated 20 case files. It should be emphasized that the Board acts in an advisory capacity only, and that the granting of a driver's license remains the responsibility of the Public Safety Department.

The Subcommittee on Safe Transportation and its chairman maintain close contact with representatives of the State Department of Health, the Iowa State Highway Patrol and the State Department of Public Safety to insure proper coordination of projects and activities which are of mutual interest and concern.

ARTHUR H. DOWNING, M.D., *Chairman*

PUBLICATIONS COMMITTEE

These comments on THE JOURNAL OF THE IOWA MEDICAL SOCIETY will be brief. It is understood financial aspects of the JOURNAL will be discussed in a supplemental report to be presented by the Board of Trustees.

It would be most appropriate in this report to acknowledge the long and distinguished service of Edward W. Hamilton, Ph.D., as Managing Editor of the JOURNAL. Mr. Hamilton retired from this position at the

end of February. His conscientious efforts through approximately 18 years have been of significant benefit to the medical profession in this state and beyond.

The JOURNAL is indebted to Richard M. Caplan, M.D., Director, Office of Medical Education, College of Medicine, University of Iowa. Through his efforts the supply of worthwhile scientific articles has increased sharply this past year. We are grateful to Dr. Caplan for his work in behalf of the JOURNAL.

Members of the 1970 House of Delegates may be assured that those involved in the publication of the JOURNAL will do their utmost to produce a monthly magazine of a high quality. Suggestions, case reports, scientific manuscripts and news items are welcome at any time.

DENNIS H. KELLY, SR., M.D., *Editor*

Reports of Special Committees

COMMITTEE ON BLOOD BANKING

The Committee on Blood Banking has not met formally this year, but its members, as individuals have maintained close liaison with the Iowa Association of Blood Banks (IABB) and the American Association of Blood Banks (AABB) on matters of possible concern to the Iowa Medical Society.

Your Committee and the Iowa Association of Blood Banks pressed vigorously for the addition of the implied warranty exclusion to the Uniform Anatomical Gifts Act. The Iowa Medical Society's Legislative Committee worked diligently on this project, and the measure received favorable consideration from the Legislature during the 1969 Session (H.F. 305). The Bill contains a provision that in Iowa the administration of blood and the transfer of human tissue is a medical service rather than the sale of a product. This will clearly eliminate the threat of implied warranty which has been a concern of many Iowa physicians.

There is still a serious shortage of voluntary blood donors in some communities. Des Moines and Iowa City are particularly affected by this problem, and they are forced to adopt the costly and technically unsatisfactory alternative of purchasing blood. We recommend that the IMS NEWS BULLETIN periodically include a flier urging physicians to remind their patients of the critical need for blood replacement. The Committee on Blood Banking is in a position to provide appropriate copy for such a campaign.

W. S. PHETEPLACE, M.D., *Chairman*

AD HOC COMMITTEE RE: DELIVERY OF HEALTH SERVICE TO A RURAL AREA IN NEED

This special *ad hoc* Committee was appointed by the IMS president, in coordination with the Board of Trustees, early in January, to study the feasibility of the Society's establishing a model for providing health services in a selected rural area in Iowa which does not now have adequate physician coverage. The organizational meeting of the *ad hoc* Committee was held on January 14.

At future meetings, consideration will be given to geographical areas in which a model program for delivery of health services might best be established, the type of services to be provided in the area, methods of both professional and subprofessional staffing, and possible means of financing.

The members of the Society will be kept apprised of the Committee's progress.

M. E. OLSEN, M.D., *Chairman*

COMMITTEE ON ECONOMICS OF HEALTH CARE

The Committee on Economics of Health Care has met only once this year, but its one meeting was important in that it served as a sort of launching pad for several Society actions taken during the ensuing portion of the 1969-70 year. This meeting was held jointly with the IMS Subcommittee on Public Assistance.

A graphic story of national trends in health care expenditures was presented to the two Committees. Excerpted from the program of the Third National Congress on Socio-Economics of Health Care, the presentation included such statistical findings as:

- National health expenditures increased 12.6 per cent from 1966 to 1967, and totaled 50.7 billion dollars.
- Public expenditures (federal, state and local) in 1967 amounted to 17.9 billion dollars or 35.2 per cent of the total. About two-thirds of this was federal.
- In 1967, 6.4 per cent of the gross national product went for health care, compared with 4.5 per cent in 1950 and 1955. Per capita health expenditures were $84.50 in 1950, and $250.63 in 1967.
- In 1950, 29.9 cents of each national dollar spent for medical care was for hospitalization; this amount increased to 35.4 cents in 1967. The portion spent for physicians' services did not materially change.
- In 1950, five per cent of the cost of physicians' services was financed by public sources. In 1967 this had increased to 19 per cent. It is expected to reach 25 per cent this year.

The joint meeting was held to evaluate developments which threaten further governmental regimentation and more inflexibility for the private practice of medicine. These several areas were considered: (1) the usual and customary fee concept; (2) additional governmental restrictions on medical practice; (3) the need for medical-professional leadership in the area of medical care costs; (4) the appropriate support for private-care programs which serve needy persons, and (5) the recognition of peer review as a highly desirable mechanism in the maintenance of a viable health-care system.

Nine points emerged from the meeting and were incorporated into a report which was presented to and approved by the IMS Executive Council. These points are felt to be worthy of reiteration for the benefit of the House of Delegates:

1. The Iowa Medical Society will have to provide a more aggressive voice, both within and outside its membership.
2. The IMS should arrange, when necessary and if possible, to appear before federal legislative bodies—e.g., Senate Finance Committee—to express itself on health-care problems in Iowa.
3. The IMS should become more forceful in its dealings with HEW and, in Iowa, with the State Department of Social Services.
4. Whenever possible the IMS should underscore its belief in principles and ethics, and should translate this belief into concerted action.

5. The IMS should be unrelenting in seeking use of the usual and customary fee concept, and should see to it that the concept is applied honestly and fairly by all associated with it.

6. The IMS should provide a review system which is more aggressive and effective than the present one.

7. The IMS should urge its officers to stay abreast of developments, and it should support the actions taken by its officers.

8. The IMS should accept its rightful responsibility in terms of public accountability.

9. The IMS must demand honesty on the part of all those with whom it has any dealings.

As mentioned at the outset of this report, these recommendations, sustained by the Executive Council, have constituted a springboard for various of the Society's efforts this year, particularly those associated with peer review.

While the Society has no thoughts of revising or reprinting its 1962 Relative Value Index, it is perhaps desirable to report the publication of a new (1969) California Relative Value Study. A copy of this document has been obtained for reference use by the IMS. In this regard, it might be reported there is some interest in and need for a universally acceptable system of coding procedures for use by the private insurors, by government and by others. The Committee may be called on to consider this further as time passes.

The Committee has had occasion to consider individual concerns expressed this year by member physicians. The interest of these physicians in matters relating to the economics of health care is to be commended.

It should be noted, as a conclusion to this report, that the Society's principal officers have devoted much time this past year to matters relating to Medicare, Medicaid, peer review, etc. Their effort deserves to be recognized.

C. O. ADAMS, M.D., *Chairman*

COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED

The Committee on Employment of the Handicapped has come into existence this year through the interest and effort of Society President W. M. Krigsten, M.D. The Committee was appointed by Dr. Krigsten shortly after he took office in April.

The Committee consisted initially of eight physicians from different parts of the state and from different areas of medical specialization. We regret that its ranks were reduced by one with the death of our respected associate, Frank G. Ober, M.D.

We were pleased to have had at our first meeting Mrs. D. W. Coughlan, president of the Woman's Auxiliary to the Iowa Medical Society, and to learn from her of the Auxiliary's desire to assist the Committee in projects it may determine to undertake.

The Committee agreed at the start of its deliberations to gather and evaluate available information about existing rehabilitation programs in the state. This fact-finding was considered a necessary first step in gaining an understanding and appreciation of programs and problems in this important area. In this process the Committee has obtained for review several printed reports, including the recently completed summary of the Comprehensive Statewide Plan for Vocational Rehabilitation Services.

In addition, the Committee has had an opportunity to meet and visit personally with five persons whose exposure and responsibility in this area have been significant. The Committee conferred on October 9 with Mr. Jerry Starkweather, associate superintendent and director, Division of Rehabilitation Education and Services, State of Iowa; Mr. John Taylor, assistant director, Iowa Commission for the Blind; Mrs. Evelyne Villines, executive secretary, Governor's Committee on Employment of the Handicapped; Mr. Rolfe Karlsson, executive director, Easter Seal Society for Crippled Children and Adults of Iowa, Inc.; and Mr. Robert Hibbeler, rehabilitation director, Goodwill Industries.

Extensive information has been provided to the Committee by these several sources. From these data there are several statistics which may be of interest to the House of Delegates. According to recent estimates, there are 167,000 physically or mentally handicapped people in Iowa. The breakdown of these has been reported as follows: 11,000—mental illness, emotional problems, alcoholism, severe personality problems or anti-social behavior; 40,000—mental retardation; 25,000—cardiac and circulatory disorders; 35,000—physical deformities, paralysis or amputations; 56,000—impairment of vision, hearing, speech, ability to breathe or ability to perform other bodily functions. It is estimated that in the neighborhood of one-third of those on welfare are candidates for rehabilitation.

In its deliberations to date the Committee has concurred, not surprisingly, that the physician does have an important role to play in the rehabilitative process—in getting a person ready for employment or re-employment, in making some educated assessment of the level of responsibility which should be assigned, etc. The Committee agrees that the element of individual motivation is likely the single most important factor. The well motivated individual who may become handicapped will often seek out and undertake some form of gainful endeavor on his own.

The aforementioned officials have impressed the Committee by their sincerity and by their desire to have the medical profession as a principal source of expertise in the development and conduct of the various programs intended to benefit the handicapped person.

It is apparent from the discussions with these individuals that there is much programming for the handicapped person in the state about which physicians have limited or perhaps no awareness. This belief is based on the fact that much of the information shared with the Committee was previously unknown to the members. The Committee has wrestled briefly with ways in which this information might be effectively provided to the physicians of Iowa. Various ideas are being explored and will receive further attention by the Committee. These include (1) a concerted effort to arrange for programs at county society meetings on the subject of employment of the handicapped; (2) the preparation and distribution of a folder summarizing in concise language the various programs and services available to which a physician may refer a patient; and (3) the stimulation of participation by physicians in local committees to work with employers and labor in advancing the hire-the-handicapped philosophy.

In an October 22, 1969, report to the IMS Executive Council, the following five recommendations were

submitted by the Committee and approved by the Council:

1. That the State Division of Rehabilitation, Education and Services provide more information "feedback" to physicians, as a means of encouraging better reports from physicians.

2. That the forms now utilized in the Vocational Rehabilitation and Social Security Disability Programs be altered to make them distinctive, as a means of aiding the physician in identifying the program in question and in preparing his response.

3. That the IMS Legislative Committee be cognizant of the need for more adequate state funding if the effectiveness of rehabilitation programs in Iowa is to increase and keep up with the needs of the handicapped.

4. That ways and means be found to disseminate information about rehabilitation services to the people of Iowa, and particularly to physicians, nurses and paramedical personnel by printed materials, by speakers at county society meetings and possibly by the Woman's Auxiliary.

5. That the Committee on Employment of the Handicapped discuss with a representative of the University of Iowa College of Medicine possibilities for expanding student knowledge of the various rehabilitation programs.

The Committee is now concerning itself with the implementation of these recommendations. On March 4 the Committee is scheduled to meet with a member of the College of Medicine faculty to discuss recommendation No. 5.

The Committee feels its progress to date has been worthwhile, particularly from the standpoint of establishing communications with key persons in the rehabilitation field. The House should know of the pleasure which these representatives have expressed over the demonstration of interest and concern on the part of the Society.

W. J. ROBB, M.D., *Chairman*

COMMITTEE ON EYE CARE

During the 10 months since the 1969 session of the IMS House of Delegates, the Eye Care Committee has held no meetings, but the chairman, IMS staff members and IMS legal counsel have represented it on several matters. The Committee members have been kept informed of developments, and their advice has been sought.

Beginning at about the time of the 1969 IMS annual meeting, IMS legal counsel has worked with the attorney for the defendant in the suit brought in district court at Des Moines by the Iowa Optometric Association vs. the Whylie Opticians, Inc., and has made preparations for the IMS to intervene on behalf of the Whylie firm when and if necessary.

In May, 1969, the chairman of the IMS Eye Committee and IMS legal counsel met with corresponding representatives of the Iowa Optometric Association to consider the possibility of scheduling a meeting of full committees from the two organizations. It appeared that each side was adamant regarding the topics at issue, and no plans were made for such a joint gathering. Members of the IMS Committee on Eye Care were so notified.

Also in May, 1969, a subcommittee of the Committee on Conservation of Hearing for the State of Iowa, of which Byron M. Merkel, M.D., is a member, concluded its study of the proposal that hearing-screening be added to the pre-school vision-screening conducted under the auspices of the Iowa Chapter of the National Society for the Prevention of Blindness. The subcommittee's report was an endorsement filled with misgivings. The following are examples of the latter: "The judgments that are required [from] the individuals who administer the tests are probably more critical than the judgments required [from] those who administer a vision screening test . . . ," and ". . . A speech audiometry procedure such as . . . the Minnesota program is inadequate as a screening device unless selected pure-tone techniques can be used to double check."

It was subsequently decided that hearing screening should be attempted, on a pilot program basis, at a few of the places where vision-screening is done in Iowa. An evaluation of the pilot program is not yet available.

In November, 1969, a number of changes were proposed for the opticians' registration bill (HF342 and SF288). One of them, offered by the opticians' organization, would have transformed it into a licensure measure. The IMS Eye Committee, together with the IMS Committee on Paramedical Services, has long believed—and the House of Delegates has sustained such beliefs on several occasions—that opticians should work under the supervision or at the direction of doctors of medicine, and thus should be registered rather than licensed. The Committee, moreover, has thought it highly desirable that the examining and registering or certifying of opticians should be done under the supervision of the State Board of Medical Licensure. It is in the best interests of the public and of doctors of medicine, as well as of the opticians themselves, that opticians continue performing all of the services that they have performed traditionally, and it has become advisable, first, to set up legal qualifications for persons aspiring to become opticians, and second, to enumerate their privileges and responsibilities in the Code of Iowa.

The chairman of the Eye Committee and IMS legal counsel met with the opticians' representatives late in November, and persuaded them that changing their objective from registration to licensure probably would doom their efforts. Some minor changes in the bill were agreed upon at that time, and when they were submitted to the members of the Eye Committee by mail, all of them approved.

It is hoped that the General Assembly of Iowa will adopt the measure as amended, and that the governor will sign it during the 1970 session.

A. H. DOWNING, M.D., *Chairman*

COMMITTEE ON GROUP INSURANCE

The several group insurance programs provided by the Iowa Medical Society to interested member physicians remain available and continue to afford good protection for those choosing to be participants.

The Blue Cross-Blue Shield Statewide Physicians' Group Program has approximately 800 participants. The program provides 365-day comprehensive coverage for both Blue Cross and Blue Shield. It includes six different deductible options from which IMS members may choose.

In the most recent experience report (for the period 7/1/68 to 7/1/69), the Statewide Physicians' Group Program was shown to have administered 394 Blue Cross and 806 Blue Shield claims. The Blue Cross coverage involved 2,801 total days of hospitalization for an aggregate cost of just over $110,200. There were 311 in-

patient and 83 outpatient cases. The total sum paid out during this reporting period for Blue Shield coverage was $47,245.

Because of the substantial utilization of both Blue Shield and Blue Cross this past year, membership rates had to be increased at the beginning of 1970. For the six different options the family premium rate ranges from $13.30 to $25.40 per month. The complete rate structure was circulated to the IMS membership in a late 1969 mailing which announced the traditional open enrollment period (January, 1970). This enrollment effort resulted in 15 additional physician participants for the program and helped continue the overall participation near the 800 level.

The open enrollment period is held each year as a service to new and veteran members of the Society. At this time, new enrollments, transfers to the group, or other changes in contracts may be made. This IMS program has been in existence for many years and is worthy of consideration by all Iowa physicians.

The Prouty Company of Des Moines continues to serve as administrator of the Group Accident and Sickness Disability Income and Life Insurance Programs sponsored by the Iowa Medical Society.

The Group Life Insurance Program provides important low cost protection to all insured members. Its features include a conversion privilege which permits a shift to permanent insurance without evidence of insurability. Effective January 1, 1969, dividends payable under the Life Program were increased, the end result being a lower cost of insurance to the members. This Life Program is underwritten by The Bankers Life of Des Moines. The Prouty Company also continues to offer to members of the Woman's Auxiliary term life insurance on a group basis.

It should be pointed out that in 1969 The Prouty Company was authorized to offer to IMS members an HR-10 (Keogh) Retirement Program. Offered through The Prouty Company by The Bankers Life of Des Moines, the program does not carry any Society endorsement or sponsorship requirements or obligations; it merely is available to those physicians who may be interested.

In line with this, it might be noted further that the recent passage of "professional corporation" legislation by the Iowa General Assembly will open new possibilities to IMS member physicians. A recent IMS NEWS BULLETIN (February 10, 1970) sets forth the various factors to be considered in evaluating the merits of a professional corporation.

In 1969 the IMS sponsored Group Disability Income Insurance was offered on a guaranteed renewable basis. This new guaranteed renewable feature represents a major improvement in the program. The Prouty Company believes the guaranteed renewable provision will increase participation in the program substantially. Many of the younger physicians will likely take advantage of the plan thereby helping to establish a viable, long-term program.

In 1969 there was an increase in the usage of benefits under the disability income plan. A loss experience has been noted in each of the past few years. Because of this loss experience, after six consecutive years, the 10 per cent surplus coverage previously available to IMS members from the Commercial Insurance Company without charge was suspended effective November 1, 1969.

Society members are encouraged to investigate the group life and disability programs which are available and to consider participation in them. For more detailed information, IMS members may either contact Society headquarters or The Prouty Company, 2124 Grand Avenue, Des Moines, Iowa 50312.

As previously mentioned, the recently enacted "professional corporation" legislation will have a positive impact on those several professions involved and will provide to the self-employed professional the same tax benefits which are now available to corporations. This development is likely to diminish the appeal of Keogh plans for physicians.

Finally, as noted in the report of the Medico-Legal Committee, the Society is following with interest a group program in the professional liability area which is being attempted by the Nebraska State Medical Association. A request has been made of the Nebraska Association that the IMS be provided word regarding the acceptance of this new program.

R. S. GERARD, II, M.D., *Chairman*

HISTORICAL COMMITTEE

The IMS Historical Committee held no meetings during 1969, but is planning one for next summer, at which ways of stimulating physicians' interest in recording Iowa medical history will be discussed.

Historical papers continue being submitted to the Society, and I should like to call attention to one of them as an especially fine example despite the fact that it required no poring over books or leafing through yellowed newspapers. Instead, it came "right off the top of the author's head." It is "Pioneer Medical Practices," by Eugene H. McCaffrey, M.D., of Des Moines, and it was published under the heading "Medical History" in the September, 1969, issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Much of medical history consists of catalogs of the names and dates of the physicians who served specific geographical areas during the early years. Dr. McCaffrey's, however, is an autobiographical narrative, rich in anecdotes recounting the diagnostic technics and the modes of treatment that were in use half a century ago, describing the storms and the poor roads that he encountered, recounting instances when he was called upon to practice dentistry as well as medicine, and reviewing the problems that tuberculosis and other contagious diseases posed before there were definitive treatments or preventives for them. In addition, he depicts many people—both laymen and his fellow physicians—and their attitudes toward medicine and the medical profession.

Those are the sorts of things that make medical history come alive, and which help to make its readers aware—as all of us want them to become aware—that medicine has progressed with incredible rapidity within the memories of men who are still active and vigorous, and that modern medical care is worth every cent it costs.

Every physician must feel sure that his own experiences are worth recording. The members of the IMS Historical Committee certainly think so, and they urge each of their colleagues "to take pen in hand."

OTTO N. GLESNE, M.D., *Chairman*

COMMITTEE ON INDEPENDENT LABORATORIES

In 1969-70 the Committee succeeded in stimulating the appointment of a Laboratory Advisory Committee to the State Department of Health. Efforts to accom-

plish this have stretched over a period of three years.

Former Iowa Commissioner of Health, James F. Speers, M.D., appointed the Advisory Committee in December. The members are C. B. Preacher, M.D., Davenport, G. R. Clark, M.D., Waterloo, J. W. Green, Jr., M.D., Des Moines, L. W. Swanson, M.D., Mason City, C. M. Blackburn, M.D., Ames, C W. Seibert, M.D., Waterloo, Wm. Hausler, Ph.D., Iowa City, and Marc Ihm, hospital administrator, Newton. The first three are members of the Society's Committee on Independent Laboratories.

The appointment of the Advisory Committee was authorized by the State Board of Health last July. It is hoped and anticipated that this Advisory Committee will be used by the Department of Health as a source of expertise on all matters pertaining to laboratory medicine, e.g., facilities, manpower, planning, etc. Efforts will be exerted to encourage the new Commissioner of Health, Arnold M. Reeve, M.D., to do so.

The Committee has taken an interest this year in various other activities relating to laboratory medicine. For instance, the Committee has become aware of a new interest in state legislation to require the licensure of laboratories and laboratory personnel. There has been no introduction of legislation to accomplish this to date, and it appears unlikely this will occur during the current session of the General Assembly. The Committee has strongly discouraged this idea of state licensure, and will remain alert to further developments. Additionally, the Committee has followed published reports regarding the possible incorporation and establishment of a lay laboratory in the state of Iowa.

Three representatives of the Committee continue to function as a subcommittee to provide liaison to the Iowa Society of Medical Technologists. This subcommittee assists in various ways, e.g., by providing guidance in the development of educational programs both for aspiring technologists and for those desiring further in-service training.

K. E. LISTER, M.D., *Chairman*

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health is currently in the process of conducting a study in which it has had an interest for several years. The Committee is well aware of the industrial growth which has occurred in Iowa over the past 10 or more years. In line with this, the Committee is curious as to the involvement of Iowa physicians in industrial medicine.

To ascertain the extent of this involvement, the Committee distributed a survey to the presidents of county medical societies in January in which three questions were asked:

1. Who are the physicians in your county engaged in the full-time practice of industrial medicine, i.e., who actually go to a plant or factory, work there all day and have no other practice?

2. Who are the physicians in your county who do part-time work at a plant or factory, i.e., who are at the plant part of the day, but who also serve other plants and may have a private practice as well?

3. Who are the physicians in your county who provide all the medical work (physical exams, injuries, etc.) for a plant or factory, but do not go to the plant regularly, providing the service, rather, from a private office where a private practice is carried on?

As would be suspected, the vast majority of the responses to date (approximately 50 per cent) show few names in the first two categories. A number of entries have been provided in the third classification. It should be mentioned at this point, however, that many of the larger counties where industry is more heavily concentrated have not yet responded to the survey.

The roster compiled from the survey responses will provide the Committee on Industrial Health a list of physicians to whom it can forward worthwhile data and from which it can gather important data.

Through the Committee, the Society participated last fall in a national survey on Workmen's Compensation conducted by the Medical Society of the State of New York. The following results from the survey have been reported to the IMS: 63.9 per cent of the states answering have free choice of physician under Workmen's Compensation; 43.7 per cent of the states are guided by a fee schedule in establishing fees for services rendered under Workmen's Compensation.

The Society and the Committee on Industrial Health were represented at the 1969 meeting of Chairmen of State Industrial Health Committees held in St. Louis, Missouri, in conjunction with the 29th annual Congress on Occupational Health. Discussed at the meeting of State Chairmen were topics such as fees paid under Workmen's Compensation, the developing interest in industrial medicine among medical students, the federal occupational safety and health act, and problems associated with industrial sound and employees' hearing.

The House of Delegates might be interested in two matters relating to the Iowa Industrial Commissioner. First, the offices of the Industrial Commissioner have been moved from the Lucas Building to the State Capitol Complex, East Sixth and Des Moines Streets. Secondly, the Eighth Annual Iowa Workmen's Compensation Symposium will be held Thursday and Friday, April 30, and May 1, at the Hotel Savery in Des Moines. This Symposium includes a medical program and is open to interested physicians.

C. H. JOHNSTON, M.D., *Chairman*

IOWA BAR LIAISON COMMITTEE

Although there has been no meeting of the Iowa Bar Liaison Committee this year, it would be in order to mention several of the instances where there has been cooperation and communication between the Society and the Iowa Bar Association.

For example, the Medical Society, the Bar Association and other professional groups have joined together in working toward passage of the professional corporation bill by the 1970 Iowa General Assembly.

Additionally, as a further illustration of joint effort, the Society's Subcommittee on Psychiatric Care has been in contact with a Special Committee on Law and the Behavioral Sciences of the Bar Association. This exchange, still in the preliminary stages, has been for purposes of assessing Iowa's commitment laws to determine the need for revision of these long-standing statutes.

The Society this year has continued to follow the disconcerting national developments associated with professional-liability coverage. Mr. Bernard Hirsh, director of the AMA Law Division, was in Des Moines in 1969 to report to the IMS Executive Council on current malpractice-insurance trends. He indicated that coverage has become prohibitive and virtually unavailable in some parts of the country, but that Iowa remains relatively fortunate in that good coverage by

reputable companies is still available here. As has been previously stated in the brief reports of this Committee, this subject is one that deserves close attention; effort needs to be exerted to find ways to discourage ill-founded malpractice cases.

R. P. LAGONI, M.D., *Chairman*

COMMITTEE ON IOWA REGIONAL MEDICAL PROGRAM AND COMPREHENSIVE HEALTH PLANNING

Members of the IMS Committee on Iowa Regional Medical Program and Comprehensive Health Planning continue to be active in and apprised of the activities of the Iowa Regional Medical Program, the State Office of Comprehensive Health Planning, and the Health Planning Council of Iowa. HPCI is a voluntary organization which functions to promote comprehensive health planning programs on a local and areawide basis in Iowa; OCHP was established under P.L. 89-749 to promote and support state and areawide health planning that will assure comprehensive health services of high quality to every person; and IRMP was established under P.L. 89-239 to act as a catalyst and stimulus to physicians, nurses and other health professionals in speeding wide utilization of the latest developments in prevention, treatment and rehabilitation of heart, cancer, stroke and related diseases.

The Iowa Medical Society is well represented on the Iowa Regional Advisory Group of IRMP. John Sunderbruch, M.D., serves as the Society's primary member, and Terry Dynes, M.D. is the alternate member. In addition, the eleven IMS councilors were recently made official members of IRAG.

Dr. Sunderbruch was appointed to the Advisory Council/Office of Comprehensive Health Planning last summer as a representative of the IMS, joining H. L. Skinner, M.D., who has been representing the Society on the Council since its formation. Other medical representatives on the Advisory Council are Julius Conner, M.D., of the Polk County Health Department, and John C. MacQueen, M.D., associate dean of the University of Iowa College of Medicine.

The IMS has recommended several physicians for appointment to standing committees of the OCHP Advisory Council, which will make recommendations regarding specific projects and programs important to comprehensive health planning.

Your Committee chairman continues to serve as president of the Health Planning Council of Iowa, a voluntary organization spearheaded by the IMS several years ago. The Society, along with other interested agencies and organizations, continues to provide substantial financial support to the organization.

HPCI has been active in assisting in the formation of regional and/or local voluntary health planning organizations. To date, 12 such groups have been formed and 4 additional ones are in the preliminary stages of development.

HPCI cooperated with the IMS and the College of Medicine last fall in sponsoring a series of 14 meetings on the delivery of health care. The IMS joined HPCI, the Iowa Hospital Association and the Iowa Society of Osteopathic Physicians and Surgeons in arranging a series of 4 regional In-Hospital Long-Range Planning Workshops.

The Committee was pleased to note that one full day of the Annual Meeting program last year was devoted to presentations providing "imaginative approaches to the delivery of medical services." Because of the great amount of interest in this subject, members of the Iowa Regional Advisory Group and the OCHP Advisory Council were invited to the meeting as guests of the IMS.

HOMER L. SKINNER, M.D., *Chairman*

MEDICAL ASSISTANTS ADVISORY COMMITTEE

The president-elect of the Iowa Medical Society, John H. Sunderbruch, M.D., and your Committee chairman represented the Iowa Medical Society at the annual meeting of the Iowa Association of Medical Assistants, which was held in Davenport last May. As has been its custom, the Iowa Medical Society also displayed a special exhibit which focused attention on some of the important activities of the Society.

The Annual Meeting of the American Association of Medical Assistants will be held in Des Moines October 28-31, 1970, with the IAMA serving as host chapter. The Society's Advisory Committee and staff are working closely with representatives of IAMA to assist in program arrangements and other meeting details.

It has become traditional for the IAMA to sponsor a coffee bar at the opening sessions of the House of Delegates. The Medical Assistants group plans to provide this service again in 1970, and the Society is certainly grateful for this thoughtful undertaking.

The IAMA is to be commended for its many worthwhile activities.

J. F. BISHOP, M.D., *Chairman*

AD HOC COMMITTEE ON MEDICAL STUDENT MEMBERSHIP IN THE IOWA MEDICAL SOCIETY

Early in January, an *ad hoc* committee was appointed by the IMS president, in consultation with the Board of Trustees, to study the feasibility and possibility of admitting medical students to membership in the Iowa Medical Society.

Officials of the Society are aware of the increasing interest that medical students have in becoming involved in helping to determine patterns of medical education and medical practice through the mechanism of organized medicine.

The first meeting of the Ad Hoc Committee will be held on February 25, and any specific recommendations developed by the Committee will be reported to the House of Delegates in April.

JAMES F. BISHOP, M.D., *Chairman*

COMMITTEE ON MEDICINE AND RELIGION

According to the records of the Iowa Medical Society's Committee on Medicine and Religion, thirty-six counties have appointed local committees on medicine and religion. These committees have the basic responsibility for promoting and arranging joint meetings of physicians and clergymen at the local level for the purpose of discussing subjects and problems of mutual interest and concern.

Members of the state Committee will be happy to provide assistance to county committees, especially with respect to recommendations for physician/clergy programs.

Dr. L. O. Ely represented the Committee on a program concerning "Organ Transplants" which was telecast over WOI television, Ames in December, 1969. Other participants included members of the organ transplant team at the University of Iowa College of Medicine, and two clergymen from Ames.

Your Committee chairman plans to attend a region-

al workshop on medicine and religion which will be held in March in Chicago under the sponsorship of the American Medical Association.

R. P. FERGUSON, M.D., *Chairman*

COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

A copy of a "Utilization Plan for a 50-Bed Natural Disaster Hospital" was mailed to each county medical society last spring. The Plan was developed by the State Department of Health, in cooperation with the Iowa Medical Society's Committee on National Emergency Medical Service.

The natural-disaster hospital is a portable, packaged 50-bed emergency hospital, which is designed for quick dispatch whenever and wherever needed within the State of Iowa following a natural or man-made disaster—tornado, flood, explosion, etc.

The resources of the emergency hospital unit are sufficient to provide care for up to 300 patients during its commitment. Although only about 50 patients can be accommodated at any one time, up to a total of 200 nonambulatory patients may be prepared for transportation and evacuated for definitive medical care. An additional 100 ambulatory patients may be treated and released without evacuation. A copy of the plan can be obtained from the Iowa Medical Society on request.

The Committee is pleased to note that at the AMA Annual Meeting in New York City last July, the AMA House of Delegates (1) reaffirmed its position that proper signs be placed on interstate and other major highways to guide travelers to the nearest emergency medical facilities; and (2) recommended that the AMA emergency medical identification symbol appear on these signs, and that descriptive material and an explanation of the significance of the symbol be distributed in the driver education classes in schools and at the places where vehicle licenses are issued.

R. C. LARIMER, M.D., *Chairman*

COMMITTEE ON ONCOLOGY

It was not necessary for the Committee on Oncology to meet during the past year. However, a member of the Committee represented the Iowa Medical Society at a meeting scheduled by the Cancer Categorical Advisory Committee of the Iowa Regional Medical Program. Representatives of several other interested organizations also were present, and the meeting was held to discuss various approaches to the cancer problem in Iowa, and methods of coordinating and exchanging useful and pertinent information.

Several suggestions were made regarding organized courses of instruction about cancer in the schools.

It is anticipated that future meetings will be scheduled by IRMP, and the Iowa Medical Society will continue to be represented by members of the committee.

G. R. CLARK, M.D., *Chairman*

COMMITTEE ON ORGAN TRANSPLANTATION

This Committee was set up to study the broad area of organ transplantation, to outline the basic fundamental medical and ethical principles relating to transplantation of organs, and to counsel and advise the State Department of Social Services as far as possible regarding its involvement under Title XIX in this area of medical service. It was activated in August of 1968 under the chairmanship of R. D. Liechty, M.D. It has had a number of meetings concerning the practical aspects of organ transplantation.

During the current year the Committee has had two meetings. At these meetings the major topics discussed were: (1) the development of the renal transplantation program at the University of Iowa; (2) the definition of death and the use of cessation of cerebral activity in making the diagnosis; and (3) dialysis and related activities in the State of Iowa.

The Committee recommended that the chairman present to the IMS Executive Council, on October 22, a report of its activities and ask for support of the program now being implemented to retrieve cadaver organs for transplantation. The Executive Council approved this program in principle. The Committee also asked the Executive Council to recognize the need for more dialysis units in Iowa and to support proposals now before the General Assembly of Iowa to develop and provide financing for dialysis centers in Iowa community hospitals. The Executive Council approved this request as well.

Although the transplantation of other viable organs prolongs human life only for limited periods, developing a program for renal transplantation is a pressing, practical problem for the people of Iowa, since this procedure usually allows the recipient to return to normal life. The most satisfactory results are obtained in patients for whom kidneys have been donated by living related donors or who receive well-matched cadaver kidneys. Since less than half of the eligible patients have even the possibility of receiving a well-matched kidney from a relative, it is obvious that most patients must receive cadaver kidneys. In order to provide a good immunologic match, it is necessary for us to have a relatively large number of patients under dialysis and ready to accept an appropriate kidney when it suddenly becomes available. It is estimated that if there were a pool of approximately 100 patients on dialysis ready for transplantation in the State of Iowa, a good match and a successful cadaveric transplant could be achieved in the majority of cases when kidneys become available. In order to provide care for these 100 patients while awaiting transplantation, other dialysis facilities in the state will be necessary. Hence, the Committee's concern about the current legislation to support dialysis facilities in community hospitals and the program about obtaining cadaveric tissue in hospitals over the state. Based on national figures and on local experience, some 90 to 150 patients who are in the proper age group and otherwise are good candidates for transplantation, develop end-stage kidney disease annually in the state of Iowa.

WALTER M. KIRKENDALL, M.D., *Chairman*

OSTEOPATHIC AND MD/DO LIAISON COMMITTEES

For the benefit of delegates who may not be altogether familiar with the IMS/ISOPS Evaluation and Enrollment Program, it may be well to review it here, as briefly as possible.

During the past seven years, or slightly longer, the Iowa Medical Society and the Iowa Society of Osteopathic Physicians and Surgeons have conducted an Evaluation and Enrollment Program by means of which osteopaths have applied for, and if approved at each of several steps, have been accepted as "individuals with whom it shall not be considered unethi-

cal for doctors of medicine to associate professionally."

That program was initiated by the IMS House of Delegates in consequence of an action by the AMA House of Delegates authorizing AMA-component societies to establish systems for judging the competence and the ethics of the osteopaths in their respective areas, and to remove the ethical barrier which theretofore had impeded M.D.'s from associating with them.

Under the program outlined by the IMS House of Delegates and implemented by the MD/DO Liaison Committee osteopaths have been considered individually, and the qualifications that each applicant osteopath must satisfy have been:

1. Holds Iowa Osteopathic Physicians and Surgeons license
2. Practices scientific medicine competently
3. Agrees to observe the AMA Principles of Medical Ethics

The steps in the process have been:

1. Iowa Society of Osteopathic Physicians and Surgeons receives and approves the applicant osteopath's application, and forwards it to the IMS headquarters.
2. IMS sends a copy of the application to the medical society in the osteopath's county, and asks it to recommend either that the applicant be approved or that he be disapproved.
3. The county medical society evaluates the applicant and notifies the IMS of its decision within 90 days.
4. The IMS Osteopathic Committee and the MD/DO Liaison Committee pass upon the applicant.
5. The IMS Judicial Council considers the recommendations of the county medical society and Osteopathic Committee, and enrolls or refuses to enroll the applicant.

In practice, the action of the county medical society has been the controlling factor although a few hearings have been conducted by the MD/DO Liaison Committee on appeal by osteopaths who had been refused enrollment. To date, the Osteopathic and MD/DO Liaison Committees and the IMS Judicial Council have approved and enrolled each applicant osteopath approved by the appropriate county medical society, with one exception, and have disapproved all of those whom county medical societies have turned down.

The current "box score" is as follows. It should be noted, however, that some of the individuals included in the tabulation may since have died, or may have retired and/or left the state.

Current Status of the IMS/ISOPS Evaluation and Enrollment Program

Approved by the IMS Judicial Council	165
Approved by a county medical society and pending action by the IMS Judicial Council	0
Hearings held by MD/DO Liaison Committee on appeal from disapproval by IMS Judicial Council	7
Hearings pending	0
No reply from county or pending at the county level	16

Quite a number of significant developments have occurred within the past two or three years that have brought osteopaths and M.D.'s closer together. In 1963, of course, the General Assembly of Iowa established a composite Medical Licensure Board. Since then no limited-privilege licenses have been issued to osteopaths, and all candidates for Iowa licensure by examination, whether M.D., or D.O., have been required to pass identical tests. In the late fall of 1968, at its interim meeting in Miami Beach, the AMA House of Delegates used the words *suggests* and *urges* in proposing (1) that graduates of osteopathic colleges be accepted for M.D. internship and residency programs; (2) that osteopath graduates of AMA-approved residency programs be accepted for examination by M.D. specialty boards; and (3) that local and state medical societies make any necessary changes in their articles of incorporation and by-laws so as to be able to admit osteopaths to membership, and thus entitle them to membership in the AMA. To date, nine specialty boards have agreed to permit osteopaths who have completed AMA approved residencies to take the respective board examinations, and some teaching hospitals—including ones in Cedar Rapids and Des Moines, and University Hospitals, Iowa City—are considering accepting qualified osteopathic graduates as interns. Some osteopathic colleges are reluctant to furnish their graduates' credentials to M.D. teaching hospitals, but others—the Des Moines College of Osteopathy and Surgery among them—are cooperating.

It is also reported that doctors of medicine have lectured to undergraduates at the Des Moines College of Osteopathy and Surgery.

Members of the 1969 IMS House of Delegates will recall that, on the recommendation of the Reference Committee on Miscellaneous Business, the Standing Committee on Articles of Incorporation and By-Laws was instructed to draft requisite changes in the IMS Articles of Incorporation and By-Laws, for consideration in April, 1970, by the House of Delegates to permit qualified osteopaths to apply for some type of membership in the Iowa Medical Society and component medical societies. The committees appreciate the hard work of Mr. Edw. W. Hamilton, staff liaison, Mr. Robert D. Throckmorton, legal counsel, and members of the IMS staff.

J. M. RHODES, M.D., *Chairman*

COMMITTEE ON PARAMEDICAL SERVICE

As has been noted in past reports of the Committee on Paramedical Services, the Society constantly follows the various important activities of those paramedical groups which serve the physician in a supportive way.

For example, a legislative matter continuing to receive Society attention has to do with the registration of opticians. This measure has been before the General Assembly for some time, but is now stymied, at least in part, by action of the Iowa Optometric Association in filing suit against an optical company to prevent its opticians from filling prescriptions for contact lenses.

Several other legislative proposals are broadly related to the paramedical area—e.g., a bill to license nursing-home administrators, a bill requiring ambulance operators to hold permits, and a bill to license hearing-aid dealers.

Recently, there have been rumors of a renewed interest in the licensure of medical laboratories and medical laboratory personnel, but no legislation of this kind has been introduced. The Iowa Association of Pathologists is on record in opposition to such action.

The desire of the clinical psychologists to gain state licensure appears to have diminished, for at this time there is no knowledge of any legislative proposals of this nature.

It continues to be the Society's position that a strong

and well operated voluntary registration program is more desirable for a paramedical group than is statutory licensure.

Through various means, this past year, the Society has continued its contacts with various of the principal paramedical groups. The eight-member Iowa Health Council is one avenue by which the Society fosters a relationship with fellow professionals and with those aiding the physician in the delivery of health care. Through the Society's Task Force on Medical Manpower, attention has been given to the development of paramedical-education programs and to the recruitment of persons into these programs. The Society has developed a new line of communication this year with the dietitians through affiliation with the Nutrition Council of Iowa.

Finally, an item worthy of note, the Iowa Chapter of the American Association of Medical Assistants will be host to the organization's national meeting in Des Moines this coming fall.

J. T. BAKODY, M.D., *Chairman*

PRECEPTORSHIP COMMITTEE

At a recent meeting of the IMS Preceptor Committee and representatives of the University of Iowa, it was reported that the faculty of the College of Medicine had approved changes in the preceptorship program, as follows:

1. The present sophomore, junior and senior medical students will participate in the preceptorship program as originally conceived—i.e., 4 weeks preceptorship between the junior and senior year.

2. Beginning with the present freshman class, a medical student will participate in a two-week preceptorship at the completion of his junior year.

It was pointed out that it has been an objective of the IMS and the College of Medicine to provide an opportunity for students to be exposed to private practice in Iowa, with the ultimate goal of retaining more Iowa-trained physicians in the state. The Committee emphasized the importance of having this occur early in a student's medical education. In this regard, it was noted that as a result of curriculum changes and the creation of a new Department of Family Practice, recently approved by the State Board of Regents on recommendation of the faculty, early exposure of medical students to medical practice in the community can be anticipated.

In considering ways to place increasing emphasis on community medical practice, the Preceptor Committee approved the following proposal: That it be strongly recommended by the College of Medicine faculty that every freshman medical student spend a week with a private practitioner in Iowa as an observer, and that this time be considered a supplement to, rather than a substitute for, the new program which requires a two-week preceptorship at the conclusion of a student's junior year.

At the request of the Committee, contacts will be made with the IHA to determine its interest in cooperating with the IMS and the College of Medicine in developing a mechanism to assist interested freshmen medical students in obtaining employment in community hospitals as orderlies during their vacation periods.

The Preceptor Committee has recommended that the IMS, through its Task Force on Medical Manpower, continue to maintain liaison with medical students at the University of Iowa. It is the opinion of the Committee that this can best be achieved by scheduling a series of informal "smoker" sessions similar to those held in past years, whereby the students have opportunity to "rub shoulders" with physicians in private practice, and to exchange ideas and information with them.

The Committee wishes to announce that the list of physicians participating in the Preceptorship Program is being updated, and that members of the IMS who are desirous of serving as preceptors should contact the Dean's office, College of Medicine.

It should be noted that L. D. Caraway, M.D., chairman, and W. E. Rouse, M.D., member of the IMS Preceptor Committee, have accepted appointments to the Preceptor Committee of the University of Iowa College of Medicine, as official representatives of the Society.

L. D. CARAWAY, M.D., *Chairman*

COMMITTEE ON QUACKERY

The Iowa Medical Society continues its active opposition to any legislation which seeks to re-define the practice of chiropractic, as exemplified in a Chiropractic Bill (S.F. 91) now in the Judiciary Committee of the Iowa Senate.

Detailed briefs stating the position of the IMS have been provided to legislators, along with other appropriate informational materials. It is stressed that medicine's opposition is based on the premise that chiropractic is an "unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease."

Particular attention has been called to a study completed by the Department of Health, Education and Welfare *(The Independent Practitioners Study)* which recommends that Congress continue to exclude chiropractic from the national Medicare program. The study was given a good public airing in the state in mid-January, when the DES MOINES SUNDAY REGISTER printed a very comprehensive and lengthy article on the subject of chiropractic, with special references to the HEW report.

Following a meeting last summer involving representatives of the IMS Committees on Quackery, Public Relations and Legislation, the Quackery Committee met to develop specific proposals for implementing an immediate and long-range legislative program dealing with chiropractic, and they were subsequently approved by the Executive Council, and referred to the Society's Legislation Committee.

In essence, it was agreed that every effort should be made to maintain the status quo insofar as existing Iowa law is concerned. In this connection, it was felt that the Legislative Committee should determine the best method of assuring that Iowa's law remains unchanged; further, the Committee should establish appropriate contacts with everyone who supports this position. In addition, it was recommended that consideration be given to stimulating a legislative study of chiropractic as a health-care provider, if this approach seems necessary in maintaining the status quo. In making this recommendation, the Committee pointed out that it is important for the public to become fully informed about the cult of chiropractic so that it can assume a major role in limiting its practice.

Last October, a member of the Quackery Committee and staff attended a Regional Conference on Chiropractic, sponsored by the American Medical Association. The major portion of the meeting was devoted

to a review of the chiropractic legislative programs of the various states involved in the meeting (Iowa, Michigan, Kansas, Minnesota, Ohio, South Dakota, Illinois and Wisconsin). During the meeting, special note was taken of recent major developments with respect to chiropractic: (1) the HEW Report regarding the exclusion of chiropractors from Medicare; (2) a strong public stand against chiropractic by the National Council of Senior Citizens; (3) publication of a new book by Ralph Lee Smith entitled AT YOUR OWN RISK: THE CASE AGAINST CHIROPRACTIC. The IMS, along with the AMA and other state medical societies, are using these materials to inform the public about the true nature of chiropractic.

Your Committee chairman is privileged to serve as a member of the Quackery Committee of the American Medical Association.

R. A. BERGER, M.D., *Chairman*

COMMITTEE ON RURAL HEALTH

The IMS Rural Health Committee has held no meetings during the past year, and no problems have been referred to it.

The delegates' attention, however, is called to a brief report from the *Ad Hoc* Committee Re: Delivery of Health Service to a Rural Area in Need, which is contained in this HANDBOOK.

M. E. OLSEN, M.D., *Chairman*

COMMITTEE ON SPORTS MEDICINE

The Committee on Sports Medicine has continued to concern itself mainly with a research and experimental study having to do with "The Prediction of Body Weight of High School Wrestlers." The principal investigator for this study has been Charles M. Tipton, Ph.D., of the University of Iowa Department of Physical Education.

The study has been underwritten by the Iowa High School Athletic Association, with some additional support provided by the Scanlon Medical Foundation/Iowa Medical Society. The study, now in its second experimental year, is seeking to identify a formula which when applied to certain skeletal measurements produces minimum and ideal body weights for high school wrestlers. The formula, derived from an equation devised by Hall of Illinois, is being modified at the present time to improve its predictability.

Of particular concern to Dr. Tipton and the Committee at the moment are the findings from the most recent data-gathering phase of the project (20 high school wrestling teams were measured in the fall of 1969). These findings suggest that Iowa prep wrestlers in many instances are losing excessive weight too rapidly. The Committee has been assured by Dr. Tipton that upon completion of the investigation of the 1969-1970 wrestlers, a reliable weight prediction formula will be available. With this assurance and with another meeting scheduled for April 1, 1970, to further assess the project, the Committee has unanimously supported the following recommendations and presents it to the 1970 IMS House of Delegates:

That the 1970 House of Delegates urge the Iowa High School Athletic Association to adopt and implement, for a trial period, the Tipton weight determination plan in its wrestling program, bearing in mind the following provisions in this plan:

1. That trained and paid persons be made responsible for gathering measurements, with a team of "measurers" formed by each high school conference to serve its member schools.

2. That these measuring teams assume responsibility, following a training clinic, for obtaining the raw data and forwarding the figures to Iowa City for analysis and projection.

3. That a requirement be instituted making it mandatory for any wrestler desiring to compete below his minimal weight to do so only with the approval and under the supervision of a physician. (It is estimated that 10 per cent might fall into this category, about 300 of 3,000 prep wrestlers.)

4. That participation in the weight-determination program be made mandatory and that the schools join in underwriting the cost of the service.

5. That the program be instituted on a trial basis.

It has been interesting and pleasing to the Committee to hear of the inquiries from other states regarding this project. It appears likely a number of states will adopt the Iowa plan for wrestling weight determination, should (1) the present formula refinement phase of the project proceed as expected, and (2) the proposed trial phase of the program work out satisfactorily.

The Committee wishes to note that a new booklet for coaches and athletes on diet and nutrition has been prepared by the Iowa State University Extension Service in cooperation with the Iowa Medical Society Committee on Sports Medicine and the Iowa High School Athletic Association. The booklet has been distributed to schools and coaches.

The IHSAA has reported additionally there has been a wide acceptance among the high schools of the physical examination form devised by the Committee within the recent past.

The Committee is pleased finally to report it has been able to develop an excellent rapport with representatives of the Iowa High School Athletic Association.

W. R. VAUGHAN, M.D., *Chairman*

STATE CLAIMS REVIEW COMMITTEE

During 1969, the claims review system of the Iowa Medical Society has undergone some changes. The county claims review was incorporated into a District Peer Review program following action by the IMS Executive Council. The Board of Trustees will be reporting in detail to the House of Delegates on this subject.

The activity of the Peer Review program has increased during the past year due, in part, to the more refined administrative procedures established by the Iowa Medicare Carrier. This pertains specifically to the Quality Assurance Program of the Carrier.

The State Claims Review Committee will submit a more detailed report to the House of Delegates in April describing the type of cases that have been reviewed. The committee will also attempt to provide some guidelines which may assist physicians in avoiding having future cases submitted to Peer Review.

The special Subcommittee created to study the administrative problems relating to the payment for surgery and surgical assistants under Medicare has met during the past year with the Carrier and HEW officials in an effort to reach some satisfactory conclusions to this obvious problem area. It is anticipated that a final report will be ready for the House of Delegates meeting in April.

R. S. GERARD, II, M.D., *Chairman*

The Tobacco Institute believes the American public is entitled to complete, authenticated information about cigarette smoking and health.

The American Cancer Society does not seem to agree.

Is the public entitled to complete, authenticated information about research on cigarette smoking and health? The Tobacco Institute thinks it is; the American Cancer Society apparently thinks it is not.

The Tobacco Institute has recently challenged the Cancer Society on a matter of importance to the public—and the public health. The Cancer Society has not accepted this challenge.

On February 5, the Cancer Society called a press conference in the Waldorf-Astoria Hotel in New York City to discuss a research project titled, "The Effects of Cigarette Smoking Upon Dogs." Through the efforts of the Cancer Society, the public was led to believe that this experiment is a landmark achievement which, for the first time, demonstrates that lung cancer, resembling lung cancer in humans, can be produced in animals with cigarette smoke.

The Cancer Society claimed that this result refutes the contention of the tobacco industry that there is no laboratory proof of a connection between cigarette smoking and lung cancer. The Society also said that the findings should have an impact on cigarettte smoking and should result in a reassessment of the advertising claims and policies of the tobacco industry.

The Tobacco Institute does not —and the public should not—accept these claims at face value. Here are the reasons:

1. The present accounts of this study are based solely upon information and interpretations provided to the press. The study has not been published in any scientific journal. The findings were not subjected, as such findings normally are, to rigorous independent scientific review.

2. This history of tobacco and health research contains many examples of experiments which were initially hailed as scientific breakthroughs, but on later evaluation proved to be of little significance. Unfortunately, the initial and premature announcement of these experiments makes news, but the later criticism of the work rarely comes to public attention.

3. The Tobacco Institute has requested the Cancer Society, in writing, to permit a thorough independent evaluation of the experiment and its results. We said we would propose as reviewers men of outstanding competence and integrity, with wide experience in areas relevant to the data, who, we believed, would be thoroughly acceptable to the Society. We also stated that if the Society should, for good reason, reject any scientist we propose, we would nominate a substitute. Finally, we offered to bear all costs needed for this independent analysis.

The Cancer Society has twice rejected this proposal—in letters dated March 12 and April 17.

We continue to hope that the American Cancer Society will permit the examination of this work in the manner we have proposed. If the study is as important as the Cancer Society has represented it to be, the Society should have no hesitation in submitting if for review.

The tobacco industry recognizes and accepts a responsibility to promote the progress of independent scientific research in the field of tobacco and health. In discharging that responsibility, we believe that the industry has spent, and continues to spend, more money for such research than any organization in the United States.

If the Cancer Society continues to deny access to this recent work, we believe this will serve as convincing evidence to the public, lay and scientific, that the data will not support the allegations made at the Society's Waldorf-Astoria conference.

We will be pleased to send the complete text of all correspondence on this matter between the Cancer Society and The Tobacco Institute to any interested individual or group.

The Tobacco Institute

1776 K Street, N.W., Washington, D.C. 20006

FROM THE TOBACCO INSTITUTE

March 20, 1970

Mr. William B. Lewis
Chairman of the Board
The American Cancer Society
219 East 42nd Street
New York, New York 10017

Dear Mr. Lewis:

I have your letter of March 12, 1970. I am greatly disappointed that the American Cancer Society has refused to permit the impartial review of the Auerbach-Hammond data which I requested in my letter of February 27. Since the Society has called upon the cigarette industry to reassess its policies in light of the findings, it is only fair and proper for the Society to permit us to have those findings evaluated by independent experts—and immediately.

You will recall that I propose to nominate as reviewers several well-known scientists highly qualified in the fields of experimental work, tumor pathology and lung diseases. They will all be subject to your rejection for good cause.

Your reasons for denying my request, as I understand them from your letter, are that the formal papers will be published in the very near future and that a study of them will satisfy any scientific or other questions regarding the findings. I do not find these reasons for denying my request at all convincing.

First, publication in a scientific journal will not occur until many months after the Waldorf-Astoria press conference of February 5.

Second, the American Cancer Society at that press conference made serious allegations against this industry and its products. The Society said in its press release that the Auerbach-Hammond findings "should have a significant impact on the smoking of cigarettes in this country, and will probably lead to a reassessment of advertising claims and policies of the cigarette industry." These findings have been widely publicized in newspapers and the medical press. How can the Cancer Society say that serious analysis of the work must be delayed until formal publication!

Finally, the published papers cannot satisfy questions about such matters as the proper interpretation of the pathologic material, the allegation that cigarette smoke produced various effects in the dogs, the validity and adequacy of the experimental design and procedure, and in general whether, as you assert. the experiment "meets the highest traditions and protocol of scientific investigation." These matters can only be resolved by examination of the pertinent data and material.

If the Cancer Society does not accede to my request, we plan to use every means at our disposal to see to it that the medical and lay public are made aware of our respective positions in this matter. Furthermore, we intend to continue to press our request for exposure of this experiment to impartial scientific scrutiny by qualified experts in the manner suggested. If the Cancer Society continues to deny access to the work, I believe this will serve as convincing evidence to the public, lay and scientific, that the Auerbach-Hammond data will not support the allegations made at the Society's Waldorf-Astoria conference.

Yours very truly,

Joseph F. Cullman, 3rd
Chairman of the Executive Committee,
The Tobacco Institute, Inc.

FROM THE AMERICAN CANCER SOCIETY

April 17, 1970

Mr. Joseph F. Cullman, III
Chairman of the Executive Committee
The Tobacco Institute, Inc.
Philip Morris, Inc.
100 Park Avenue
New York, New York 10017

Dear Mr. Cullman:

The Veterans Administration, the American Cancer Society and Doctors Auerbach and Hammond cannot accede to the requests stated in your letter of February 27 and March 20 for an evaluation of the Auerbach-Hammond study on "The Effects of Cigarette Smoking Upon Dogs" by a panel of independent scientists chosen by you.

Your request is without precedent in the scientific community. The study under question was the result of three and a half years of diligent and brilliant work by two eminently qualified scientists whose findings have been validated by distinguished pathologists of worldwide reputation. In addition, other leading pathologists, highly regarded by the scientific community, have visited Dr. Auerbach's laboratory, seen his slides and praised the work.

We do not intend to ask that these two eminent men submit their findings to any selected committee chosen by the Tobacco Institute, or any other group. Their work will be judged in the traditional manner of American science, where findings are presented, discussed, accepted or rejected by scientists and physicians whose only motivation is the truth. Doctors Auerbach and Hammond worked freely and without restraint with funds furnished by the federal government and the American Cancer Society. They are beholden only to the scientific community at large and to the integrity it represents.

If the Tobacco Institute, or any scientific research group, has doubts about the findings of this study, the way it was conducted, or the credentials of the investigators, there is a time-honored and scientifically accepted way to proceed. Let your own or another group of scientists repeat the experiments in a laboratory to prove that smoking dogs will not suffer tissue damage, emphysema and lung cancer. The Auerbach-Hammond methodology is readily available to you. And I presume that in the Council for Tobacco Research you have or can set up the mechanism for conducting such a study.

If you carry out your plan to publicize "our respective positions" to the medical and lay public, you have our permission to use this letter as the position paper of the American Cancer Society.

Sincerely,

William B. Lewis

William B. Lewis

FROM THE TOBACCO INSTITUTE

April 29, 1970

Mr. William B. Lewis
Chairman of the Board
The American Cancer Society
219 East 42nd Street
New York, New York 10017

Dear Mr. Lewis:

Your letter of April 17 states that the American Cancer Society is unwilling to permit an impartial review of the Auerbach-Hammond data by "any selected committee chosen by the Tobacco Institute, or any other group."

You say our request "is without precedent in the scientific community." I submit that the Cancer Society's exploitation of this unpublished work for publicity purposes is truly without precedent in the scientific community. Through its use of publicity techniques rather than the usual scientific channels, it is the Cancer Society—not the tobacco industry—which, contrary to the traditions of American science, has projected this study into the arena of public discussion. Furthermore, in the scientific community, expert review panels are often convened to review important questions which depend upon the interpretation of research results.

You claim pathologists have visited Dr. Auerbach's laboratory, seen his slides and praised the work. Why, then, do you refuse to permit an impartial review by distinguished scientists, especially in view of your claim that this work is of great significance to the smoking public and the tobacco industry?

As you say, Doctors Auerbach and Hammond worked with funds furnished by the federal government and the American Cancer Society. Since these are funds derived from public sources, the public is entitled to a full and fair account of the results. The American Cancer Society cannot presume to be the sole custodian and interpreter of the work.

You stated that these scientists "are beholden only to the scientific community at large and to the integrity it represents." But the American Cancer Society, an organization supported by public donations, is certainly also "beholden" to its contributors and to the public at large to provide complete information about the research which it finances, especially in view of the fact that you have released news of the study to the public media. When the Society is questioned about its interpretations of such research, it should feel a responsibility to disclose the data, which, it alleges, supports its interpretations.

You suggest that the way to resolve any doubts about the study is to have another research organization repeat the work—which you say, was conducted over a period of three and a half years. This suggestion overlooks the fact that the American Cancer Society has called upon the tobacco industry to reassess its policies in light of the present findings. If this is the Society's position, it should not expect or want the cigarette industry to go through three and a half years of research to determine answers which the Cancer Society asserts are available today.

In view of the American Cancer Society's position, we are proceeding to bring this matter to the attention of the public.

Yours very truly,

Joseph F. Cullman, 3rd
Chairman of the Executive Committee,
The Tobacco Institute, Inc.

TASK FORCE ON MEDICAL MANPOWER

As a follow-up to a series of 16 area meetings on medical manpower conducted for members of the IMS in the fall of 1968, another series of meetings was held in the fall of 1969 involving not only physicians, but other professional and allied health personnel, legislators and community leaders, as well. The meetings were held in 14 locations in the state, beginning on October 21 and concluding on December 11. They were sponsored by the Iowa Medical Society, the University of Iowa College of Medicine, and the Health Planning Council of Iowa, with cooperation from the Iowa State University Extension Service.

Officials of the IMS served as moderators for the programs; representatives of the Extension Service provided an area profile of population and economic trends; John MacQueen, M.D., associate dean, University of Iowa College of Medicine, provided an area profile of medical services and discussed what constitutes good medical services for an area; members of HPCI emphasized the need for health planning; and the program concluded with a panel discussion and a question-and-answer session regarding area planning for the provision of medical services.

At each meeting, various informational materials were distributed, including (1) copies of a "Statement on Health Care Delivery" developed by the Task Force last year, and subsequently approved by the Executive Council and House of Delegates; and (2) copies of a special newspaper section titled "State of Health Care in Iowa," which was prepared by the IMS, in conjunction with other interested agencies, and published as a supplement to an edition of the DES MOINES SUNDAY REGISTER about one year ago.

The last series of area meetings was very successful, and served as a valuable step on the Society's long-term program designed to inform the public about problems relating to the delivery of health care, and to stimulate involvement in the health planning process.

There is agreement by representatives of the sponsoring groups that efforts should be continued toward the established goal of obtaining greater public understanding of the changing patterns of health care delivery, and the need for coordinated planning to achieve the best possible standard of health care. In this regard, a concerted effort will be made to arrange speaking engagements for informed individuals before service clubs, fraternal organizations, etc. Also, efforts will be made to arrange for discussions of subjects relating to the delivery of health care and medical manpower over radio and television stations. These topics have already been presented on the WOI "Doctor's House Call" radio series, and additional discussions will be presented on the Dimension V program which is telecast over WOI-Television. Representatives of IMS, HPCI, the College of Medicine and the ISU Extension Service will participate in this program, scheduled for presentation on March 9.

The program presented at the 14 area meetings was also presented in Iowa City on January 26 for the benefit of the faculty of the College of Medicine.

The Task Force continues its efforts to maintain contact with students and graduates of the University of Iowa College of Medicine. Representatives of the Task Force are in the process of arranging a series of informal discussion meetings with medical students at each of the medical fraternities, similar to sessions held during the past two years. Copies of informational materials emanating from the IMS are provided to junior and senior medical students, to interns who are graduates of the College of Medicine, and to physicians now serving residencies at the College. All of these activities are geared toward stimulating student interest in returning to Iowa to practice medicine. The Task Force wishes to point out, however, that perhaps one of the best means of recruiting physicians for Iowa is the establishing by individual physicians, of personal contacts and communications with a potential medical student, a medical student, an intern, and/or resident.

Members of the Task Force have received copies of a new report published by the AMA titled "Models for Delivery of Health Services in Rural Areas." This material has also been made available to the *ad hoc* committee of the Society which was recently appointed to study the feasibility of establishing a pilot program for providing health care services in a rural area without physician coverage. The Task Force is represented on that *ad hoc* committee.

The Executive Council recently approved a statement concerning "Nursing Functions for Registered Nurses Practicing in Hospitals or Organized Agencies in Iowa," prepared by Section III of the Task Force (Nurse Recruitment and Education) and the Committee on Nursing Practices of the Iowa Nurses' Association. It is pointed out in the statement that R.N.'s need more specific guidance and protection in the performance of nursing activities than is provided in the necessarily broad language of Section 152.1 of the Iowa Code which defines the practice of nursing; hence, the statement offers some guidance as to which activities fall within the scope of authorized practice by an R.N.

The Task Force will continue to study problems relating to medical manpower, and will offer constructive suggestions regarding various approaches to the continued provision of high quality medical care to all Iowans.

BYRON M. MERKEL, M.D., *Chairman*

COMMITTEE ON VOLUNTARY HEALTH AGENCIES

Of particular interest to the Committee on Voluntary Health Agencies at this time is a program which accords certain recognition to those voluntary health organizations seeking it.

The Committee is studying a program wherein a voluntary health agency completes a detailed questionnaire provided by the Society. Under the program data from the questionnaire are carefully evaluated by the Committee, and if the agency is found to be operating soundly it is issued a certificate of recognition suitable for framing and posting. If instituted by the IMS, the certification would presumably be repeated on an annual basis.

A program of this nature has been instituted recently by the Indiana State Medical Association, and is apparently operating effectively. Through this program a custom is developing wherein two representatives of the ISMA have been designated to serve in a liaison capacity between the agencies and the Association.

To this point, the Committee's evaluation of this program has been favorable. Should the Committee decide to recommend that the Society undertake a similar recognition program, its recommendation will be

transmitted to either the House of Delegates or the Executive Council.

The Society was represented this past fall, as were several of the state's voluntary health agencies, at the AMA Regional Conference of Midwest State Medical Associations on Relationships with Voluntary Health Agencies. The meeting was a productive one.

As has been mentioned quite regularly, Iowa physicians serve extensively in leadership roles in the various voluntary health organizations. This activity points up the Society's strong belief that doctors should provide guidance and medical expertise to these organizations to the fullest extent possible.

Again in 1969, the Iowa State Fair "Hall of Health" afforded the IMS an opportunity to work with several voluntary health agencies. Several agencies joined with the member organizations of the Iowa Health Council to present health education exhibits at the 1969 Fair.

C. E. SCHROCK, M.D., *Chairman*

WOMAN'S AUXILIARY ADVISORY COMMITTEE

The Advisory Committee to the Woman's Auxiliary reports that Iowa's organization for physicians' wives continues to cooperate with county medical societies and with medical organizations at the state and national levels.

One goal it has achieved during the past year has been the devising of an annual convention program that will give physicians' wives from all sections of the state time to learn to know one another better, and to work with county Auxiliaries and members-at-large more closely.

Through the Auxiliary's Mental Health Committee and its new Children and Youth Committee, more approved information and materials on drugs, drug abuse, alcohol and smoking have been made available for school and community programs.

The Auxiliary's Volunteer Health Service Award, presented during its annual meeting, continues as a community public relations project. Outstanding volunteer health workers are nominated for the Award by various county Auxiliaries.

The Auxiliary's Health-Education Loan Fund has been called upon more frequently than ever during the past year for loans to students in approved schools of nursing, technology and paramedical therapies. There now are seven students receiving loans, and six have completed training and are repaying their loans. Since there have been more applications for loans in recent months, it is felt that there will be an even greater demand for funds this coming year. The Committee reports that none of its loans are delinquent at this time.

The Auxiliary's AMA-ERF Committee has continued raising funds for the AMA Education and Research Foundation and for the Scanlon Medical Foundation/Iowa Medical Society. Through the Auxiliary's efforts at the county and state levels, contributions from Iowans to the medical schools designated by the respective donors, and also to the loan program for medical students have increased. Again this year Iowa exceeded the goal that the National Auxiliary had set for it, thanks to the Iowa physicians' response to the chairman's appeal, as well as to the county Auxiliaries' fund-raising efforts.

The cooperation of the Auxiliary with the Easter Seal Society of Iowa in sponsoring sales of handicraft items made by homebound handicapped persons is a continuing top-priority public relations project. The county Auxiliary, in each instance, arranges for the sale location (furnished by a department store, a supermarket or a county-fair management), and handles all the details of the sale, including the recruiting of Auxiliary members to serve as volunteer salespeople. All proceeds from the sales go to the handicapped persons who made the articles.

Iowa's Auxiliary has been recognized at the national level, this year, through the appointment of three of its members to national committees. Mrs. Howard Ellis is the National AMA-ERF chairman; Mrs. Max E. Olsen is the North Central Health Careers chairman; and Mrs. James F. Bishop is the North Central Mental Health chairman.

The State Auxiliary's Legislative Committee makes every effort to keep the members informed on pending health legislation, in cooperation with the IMS Committee on Legislation. The State Auxiliary, assisted by the Polk County Auxiliary, sponsors an annual breakfast or tea at which members of the Legislative Ladies League are entertained. This program, approved by the IMS, has always been health-oriented, and from the attendance, year after year, it appears to be a popular project.

Many other State Auxiliary committees have been working at their assigned tasks, and have been carrying on programs suggested by the National Auxiliary and approved either by the IMS or by the appropriate county medical society.

The prime purpose of a Woman's Auxiliary is to keep physicians' wives well informed on health programs and issues, and to bring them together to support the objectives of organized medicine.

The Advisory Committee urges physicians to support the Auxiliary in every way possible, and to encourage their wives to participate by joining and working with the Auxiliary.

JOHN H. SUNDERBRUCH, M.D., *Chairman*

(This concludes the material that was published in the HANDBOOK FOR THE HOUSE OF DELEGATES.)

Dr. Caraway then introduced the following guests: W. B. Recknor, Executive Director, Iowa Medical Service; W. A. Guy, President, Hospital Service, Inc., of Iowa, and three medical student representatives from the University of Iowa College of Medicine: Peter Ferguson, Mike Hill and David Stoll.

The presentation of Supplemental Reports was the next order of business, the first of which were the Reports of Officers. Each report was referred to the appropriate reference committee for study.

Supplemental Reports

BOARD OF TRUSTEES

GENERAL ACTIVITIES—SECTION I

Presented by Kenneth E. Lister, M.D.
Chairman, Board of Trustees

(Referred to the Reference Committee on Reports of Officers.)

To provide a comprehensive but concise accounting of IMS affairs becomes increasingly difficult, since it seems that each year new problems and programs are piled on top of existing ones.

The Delegates' HANDBOOK, which I assume has been carefully reviewed by each of you, contains "nuts and bolts" information about the Society's operation and accomplishments during the past year. However, I

would like to comment on some items which demand your special attention:

Iowa Resolutions. You will recall that at the 1969 Annual Meeting, the House of Delegates approved two resolutions for submission to the House of Delegates of the American Medical Association at its Annual Meeting.

The Society's resolution calling on the AMA to limit advertising of medical laboratory services to that ethically available to physicians was referred to the AMA Judicial Council for its study and comment, along with similar resolutions from other states.

The House reacted favorably to a second IMS resolution concerning the identification of ingredients in pre-packaged mixes. As a result of the House action, the AMA was to request the U. S. Food and Drug Administration to act on an AMA proposal regarding labeling of fatty-acid composition. The AMA is also to develop a national program for identifying and labeling other nutritionally significant components of convenience foods.

IMS Annual Sessions. Also at last year's meeting, actions were taken pertaining to the scheduling of scientific programs, and the conduct of business of the House of Delegates. In brief, the Board of Trustees was requested to explore with appropriate officials of neighboring state medical societies the feasibility of combining state scientific sessions on an alternate-host basis, retaining separate House of Delegates' sessions. This proposal of the IMS has been discussed informally with representatives of the states in the North Central Medical Conference—North and South Dakota, Minnesota, Nebraska, and Wisconsin—and was also officially considered at the Annual Meeting of the NCMC last October. As a result, each state medical society in the Conference is to seek authorization from its respective governing bodies to participate in a joint effort to study and make recommendations regarding the scheduling of annual scientific sessions on a "regional" basis, and to report a definite commitment or rejection with respect to participating in the study at the North Central Medical Conference breakfast caucus that will be held in June at the time of the 1970 AMA Annual Meeting.

If no objections are expressed by this House of Delegates, and if appropriate arrangements can be made, it might be desirable to schedule a multi-state scientific meeting next fall, or at the earliest convenient time, on an experimental basis. A meeting site could be selected that would not only have adequate program facilities, but recreational advantages as well.

The Board was also requested to emphasize and define to delegates their duties and responsibilities; to study ways of providing delegates more time to consider and make recommendations on items under consideration at sessions of the House; and to educate the general membership about the structure of organized medicine and how its constitutional and representative government functions.

In reference to these recommendations, the Board of Trustees is pleased to point out that a series of three articles has been published in the IMS JOURNAL relating to the structure and operation of the IMS, and the responsibility and functions of delegates, officers and committee personnel. This information should be very useful to the membership in general, and the delegates in particular. Reprints of these articles, which appeared in the February, March and April issues, are included in the delegates' packets distributed to you this morning. It is the opinion of the Board that every effort is currently being made to provide the delegates with advance information regarding the items to be discussed, as evidenced by the numerous reports and resolutions contained in the House of Delegates' HANDBOOK which is distributed several weeks in advance of the Annual Meeting. It should also be noted that in order to keep the delegates, as well as other state and county society officers, informed throughout the year on IMS activities, a special report is mailed to these individuals each month. A sample of this report is included in your delegates' packet.

Members of the Society have been made aware that reference committee hearings are open to them, and they are welcome to attend and discuss the various matters that are being considered.

It is obvious that with a three and one-half day meeting, with two days devoted strictly to scientific presentations, time is of the essence insofar as completing the business at hand is concerned. The reference committees work long and tedious hours in conducting their open hearings, and in developing their recommendations for consideration by the House as a whole. Likewise, the staff toils in reproducing the reports so that each delegate has a reading copy in front of him when the final session of the House is convened.

To lengthen the duration of the meeting would not be desirous and any further "streamlining" of the sessions might reduce the time that is now available for the delegates to conduct their business. However, it should be pointed out that several medical societies are effecting changes in their annual meeting schedules. For instance, South Dakota has revised its annual meeting format to provide for a two-day business session and a one-day scientific session. In North Dakota, the business meetings and scientific programs have been intertwined. Nebraska has shortened its annual meeting by one day.

The Board recommends that unless there is strong objection, any decision to re-structure the House of Delegates schedule be delayed until there has been opportunity for the states in the North Central Medical Conference to express a negative or positive response to the proposal of joining together for annual scientific sessions. If this proposal becomes a *fait acompli,* then it will be essential to revise the meeting schedule of the House of Delegates.

Appointment of Ad Hoc Committees. In light of the increasing interest and great desire of medical students to become actively involved in helping to determine patterns of medical education and medical practice through the mechanism of organized medicine, an Ad Hoc Committee on Medical Student Membership was recently appointed by the Board. The Committee's positive recommendations regarding the creation of an active membership category for students at the University of Iowa College of Medicine have been submitted to the Committee on Articles of Incorporation and By-Laws and appropriate amendments in this regard are to be considered by the House of Delegates during this Annual Meeting. Student representatives have been invited to attend sessions of the House of Delegates, as well as the reference committee hearings at which this material will be discussed.

The second Ad Hoc Committee appointed by the Board is concerning itself with the development of a proposal to establish a model for providing health service in a selected rural area in Iowa which does not

now have adequate physician coverage. The committee will study geographical areas in which a model program for delivery of health service might be established, the type of service to be provided, methods of professional and subprofessional staffing, and financing. Any specific recommendations of the committee will be referred to the Executive Council or House of Delegates and the membership will be kept apprised of future progress.

Relations with the University of Iowa College of Medicine. Close liaison is maintained between officers of the IMS and the College of Medicine, and between appropriate committees and staff of the Society and college officers and faculty. Officers of the medical society have been kept apprised of progress with respect to a new Dean of the College of Medicine and the appointment of a head for the new Family Practice Department. Certainly the creation of the Family Practice Department, which was strongly supported by the IMS, will prove to be an effective step in assuring an increasing number of general practitioners for the State of Iowa.

The College of Medicine and the Health Planning Council of Iowa worked closely with the IMS in arranging and conducting the series of 14 area meetings on Health Care Delivery that were held last Fall for physicians, allied health personnel and community leaders. A special accolade is due Dr. John MacQueen, Associate Dean at the College, who was a key discussant and who participated in every one of the meetings.

Strong relations have developed between the College of Medicine and the Society with respect to planning for continuing education programs. Dr. Richard Caplan, a faculty member and Director of Medical Education at the College, also serves on the IMS Committee on Medical Education and Hospitals. A special "conference area" has been set aside for him in the exhibit section at the Hotel Fort Des Moines and he will be available to discuss potential postgraduate programs with members of the IMS. He, and the Committee on Medical Education and Hospitals, are desirous of learning firsthand about the type of postgraduate education programs that would be of most value and interest to physicians throughout the state.

Iowa is indeed fortunate in having an excellent "town and gown" relationship. As Dr. Robert Hardin, Vice President of Health Affairs at the University, stated at a recent meeting, "there is a high degree of cooperation and common endeavor between the IMS and the College of Medicine that does not exist in many other states."

Committee Activity. The Society has 50 committees —most of which are functioning on a continuing basis. Some of the projects developed as a direct result of committee recommendations and activities that deserve underscoring include the following:

. . . Sponsorship of a conference on drug abuse, along with other members of the Iowa Health Council. Arrangements for this outstanding program, which received statewide attention and publicity, were coordinated through the Society's headquarters office.

. . . Continuing study of malpractice insurance programs. Last July, Mr. Bernard Hirsh, General Counsel for the AMA, appeared before the Executive Council to discuss this important subject, and contacts are being maintained with the AMA as it considers potential new programs designed to provide physicians with some relief from the ever-increasing costs of malpractice protection.

. . . Passage of a Professional Corporations Bill during the second session of the 63rd Iowa General Assembly. This legislation was actively supported by the IMS.

. . . Sponsorship of a series of four regional workshops on Hospital Long-Range Planning, along with the Iowa Hospital Association, the Iowa Society of Osteopathic Physicians and Surgeons, and the Health Planning Council of Iowa.

. . . Participation in and coordination of arrangements for the "Hall of Health" exhibit section at the Iowa State Fair.

. . . Continued administration of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) on the basis of usual and customary fees. In 1969, $564,548.10 was paid to providers of care under this program.

. . . Cooperation in and support of the statewide Rubella Eradication Program, which was initiated by the State Department of Health late last year.

. . . Approval by the Executive Council of several recommendations developed by the Society's new Committee on Employment of the Handicapped.

. . . Active participation in the policy-making bodies of the Health Planning Council of Iowa, the Office for Comprehensive Health Planning, and the Iowa Regional Medical Program.

. . . Consultation with the Commissioner of Health regarding rules and regulations governing the operation of nursing and custodial homes in Iowa.

. . . Participation in the appointment of a Laboratory

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

A most worthwhile mechanism for creating a memorial to a relative, associate, colleague or friend exists in the Scanlon Medical Foundation/Iowa Medical Society. The Foundation utilizes memorial gifts to carry forward its loan program which has helped more than 300 young Iowans finance their medical educations. The Foundation will be glad to send an appropriate card in the name of the donor to the family of the person honored. The tax-deductible memorial gifts should be directed to the Scanlon Medical Foundation/ Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

Advisory Committee to the State Department of Health.

. . . Involvement in a cooperative study of the weight determination of high school wrestlers.

As the day progresses, some of the committees will present supplemental reports regarding additional aspects of the Society's operation. Important among these will be proposed amendments to the By-Laws which would permit the IMS and component medical societies to provide qualified osteopaths with some type of membership.

Being well aware of the full business day facing the House, and knowing that you will be called upon to consider many important recommendations and proposals, I shall bring this section of the Board of Trustees Supplemental Report to a close.

It is now my privilege to introduce to you Dr. Jerome Paulson who will continue the Report with Section II relating to Medicare-Medicaid-Peer Review. Dr. Wicks will then present Section III regarding Blue Shield, and also Section IV, which is the Financial Report.

I will appear before you one final time this morning to conclude the Supplemental Report of the Board with a most important recommendation for your consideration and action.

MEDICARE—MEDICAID—PEER REVIEW—SECTION II

Presented by Jerome F. Paulson, M.D., Trustee

(Referred to the Reference Committee on Insurance and Medical Service.)

The Iowa Medical Society officers have devoted much time this past year to matters relating to Medicare and Medicaid. There is a continuing trend on both the national and state level to make consistent, if not identical, all rules and regulations governing the Medicare and Medicaid programs.

The HANDBOOK report of the Subcommittee on Public Assistance details many of the Medicaid problem areas that have received attention by the IMS. Two items of greatest concern have been (1) the freeze on physicians' fees at the 1968 level and (2) the constant change in interpretation of what type of services are covered under Medicare-Medicaid for patients in an Extended Care Facility and/or skilled nursing home.

Early in 1969 an SSA directive placed in force a rigid upper limit on the range of prevailing charges based on 1968 physician billing records. This SSA ruling was strongly opposed by the IMS with official contact being registered with the American Medical Association in an effort to have the action reversed. This was not successful. Later by action of the Executive Council the Society voiced its grave concern over these developments in a letter to HEW Secretary Robert Finch.

This fee limit based on 1968 information by federal directive was implemented almost immediately by the Iowa Medicare Carrier for surgical services and has been in effect since early 1969. Due to the inadequate computer programs, the Carrier was not in a position to apply this same criteria to the payment of medical care.

With acquiescence from SSA, payment for medical care services has been determined through the use of statewide guidelines and not on a 1968 customary and prevailing basis. On January 1, 1970 the Carrier began applying 1968 customary and prevailing criteria on all pending claims for medical services. This modification resulted in a sudden decrease in the amount physicians were being paid for medical care under both Medicare and Medicaid. Although the order for a freeze had been in effect for some time, this partial delay in implementation served to again remind physicians of the stringent nature of federal rules and regulations.

Although those close to the program were aware that this delayed curtailment in payment of fees was forthcoming, unfortunately there was not adequate notice prior to actual implementation to allow the Society to inform its members. Only after receiving many complaints as to the cutback was the Society in a position to distribute a News Bulletin as to the nature of the fee cutback. We have taken steps to see that this lack of advance notice does not occur in the future.

During the past year the IMS distributed through News Bulletins guidelines from HEW as to covered and non-covered services under Medicare-Medicaid in an ECF and/or skilled nursing home. It is apparent that federal officials have encouraged the Carrier to reject far more claims for patients in these facilities. Federal pressure to curb the costs of Medicare and Medicaid by this method result in misunderstandings on the part of patients, physicians and administrators.

Unfortunately, the blame for this limitation is too often placed with the doctor or Blue Cross-Blue Shield (Medicare Carrier) when it properly should be directed toward federal officials. The government's effort to reduce costs are obviously misdirected when they result in a decrease in the quality and quantity of medical care intended to be provided to Medicare/Medicaid recipients by Congress.

In spite of excellent cooperation between the Society and the Medicare Carrier in Iowa (Blue Shield) and the long standing good working relationship between the Subcommittee on Public Assistance and the Iowa Department of Social Services, the federal role in these programs too often leaves the Society in an ineffective position as it tries to cooperate in improvements in the administration of Medicare and Medicaid.

Your officers wish to acknowledge the efforts in behalf of Iowa physicians of both officials of the Medicare Carrier and E. M. Smith, M.D., Medical Director of the Department of Social Services. These people have a difficult role in explaining to physicians the maze of federal regulations regarding the program, in addition to voicing to federal officials the real concern and frustration of Iowa physicians as they attempt to serve the best interests of their patients.

Without a doubt, the most disturbing aspect of the Medicare-Medicaid programs is the unfair, inaccurate and steady barrage of statements from legislators and others as to the excessive costs and abuses of both programs. These unfounded allegations often attempt to place the blame for the high cost of the programs on those who provide the service. Actual evidence to support these charges is woefully inadequate. Much of the problem relates to the demand for health services resulting from promises made by federal officials when these programs were enacted. The government triggered a demand for services without first determining that professional people were available in sufficient numbers to provide these services. Fortunately, the government is now recognizing this fact and is joining with organized medicine in efforts to increase the supply of physicians and allied personnel. The physicians of Iowa resent being the scapegoats for all the short-

comings in Medicare and Medicaid. The vast majority of physicians are honest and dedicated to providing high quality medical care at a reasonable cost. Despite efforts by IMS officers to set the record straight, too often our answers to misleading headlines and incorrect news media stories receive little attention. Within the past few weeks your officers took this message directly to Iowa's Congressmen and Senators in a personal in-depth meeting in Washington, D. C. It is our hope that the Iowa Congressional delegation now more fully appreciates the true facts relating to Medicare and Medicaid in Iowa.

Peer Review. During the past year the Iowa Medical Society has updated and strengthened its peer review system. Peer review has been an established mechanism within the Society for many years although it has not always carried this designation. As the name obviously suggests, peer review is that detailed evaluation which is made of the care rendered by a physician or by a group of his colleagues. Although the press and some legislators have often suggested that lay people should become involved in peer review, the Society has taken a strong position indicating that an objective and informed evaluation of said care can be performed adequately only by physicians. It should be emphasized that the Society does recognize the interest of representatives of the legislature, governmental agencies and others in the peer review process and welcomes the consultation and involvement of these several entities, and through the state review committee we believe this is quite possible and desirable.

As indicated in the HANDBOOK report of the Committee on Economics of Health Care, the change in the Society's peer review system is based on recommendations of that Committee and the Subcommittee on Public Assistance. These recommendations were approved by the Executive Council on July 2, 1969.

Organizationally, the peer review system consists of 11 district committees and a statewide committee. These components are under the overall administrative direction of the Board of Trustees. The state review committee serves an umbrella type of function. Its several purposes are to provide guidelines for use at the district level, to evaluate overall activity including volume and types of cases received and under what programs, i.e., Medicare, Medicaid, Blue Shield, private health insurance, etc. In addition, the state committee serves as an appeal body in those few instances where there is disagreement with the decision of a district review committee.

Enclosed in your packet is a brochure on peer review which was developed to explain the program to physicians, legislators and the general public. We suggest you take the time to read the brochure.

One aspect of peer review that has received widespread news coverage during the past year was a study of the practice patterns of 14 physicians (physicians believed to be billing separately or individually) who received 1968 payments from Medicaid in amounts in excess of $15,000. IMS made contact with these physicians to ascertain their willingness to participate in the review process. The district committees evaluated a 20 per cent sampling of 1968 Medicaid billings and made additional personal inquiry where indicated. The findings of the district committees were transmitted to the Board in September. After detailed individual review, the Board submitted its conclusions to the Department of Social Services for final action in late September. A majority of the cases reviewed revealed no evidence of abuse or over-utilization but where such evidence did appear to be present the Department was so informed.

As a result of this factual and fair review the Department of Social Services had certain physicians placed under observation by the Medicare Carrier through its Quality Assurance Program. We also understand that two cases were forwarded to the Attorney General for investigation of possible fraud. A final report has not been received on these two cases.

Organized medicine believes it has the responsibility to provide, and voluntarily, a sound and readily available peer review system. The ethical standards which guide physicians declare that the profession must assure fair and judicious delivery of health care to the public, and peer review represents a means by which this can be assured.

We have found that the review process has been asked to review cases which primarily involve the utilization of services. This has to do with the frequency of examination and treatment, particularly in extended care facilities and/or skilled nursing homes, as well as the number of visits at the physician's office. In evaluating the care provided, the review committees make the assessment based on whether a practice conforms to an acceptable pattern or if there is some abuse present.

Contrary to what many public officials would have you believe, there is virtually no way under either Medicaid or Medicare in which an excessive fee will be paid. The 1968 fee freeze placed on these programs has resulted in a tightly controlled upper limit of payment for physicians' services.

Let me emphasize that Iowa physicians are vitally interested, as are most citizens of the state, in the wise use of tax dollars and in efficiency and economy in government-paid health services, and in all health services for that matter. Combined, too, with this priority interest in fiscal soundness is the dedication of Iowa's medical doctors to the high ethical values on which the profession is built, to the elements of integrity and principle. The total program of the Iowa Medical Society, including peer review, seeks the achievement of two basic stated objectives; namely, (1) to advocate such measures as will tend to alleviate the sufferings, improve the health, and protect the lives of human beings, and (2) to establish, maintain and enforce as incidence to membership (in the Society) high standards of professional conduct and ethics.

Honesty and integrity are obvious keystones in the consideration of this entire matter. Whether he be physician or lion tamer, man must operate from the premise that his fellow men possess moral, religious and/or ethical values which make them honest. When the honesty of man is questioned at every turn, the promise of a better tomorrow stands clearly in jeopardy.

In summary, the Iowa Medical Society is making available its expertise and its manpower to assist in structuring programs which are fiscally sound and which serve the health care needs of those for whom they are intended. In situations where questions are raised as to the propriety of a physician's charge or his mode of practice, the Society is unequivocally dedi-

cated to clearing and protecting the innocent and to identifying the guilty. We believe the broad application of the professional peer review system will do more than any single thing to assure the success of this stated objective. We are willing to accept the challenge which is present in a program such as this.

Dr. Wicks will now introduce the subject of Blue Shield and the officers of Blue Shield to present their reports.

BLUE SHIELD REPORT—SECTION III

Presented by Ralph L. Wicks, M.D., Trustee

(Referred to the Reference Committee on Insurance and Medical Service.)

The 1970 advertising slogan of Blue Cross/Blue Shield provides a rather interesting means of introducing this portion of the Board of Trustees' report. Maybe you have noted either in the newspaper or over the air waves the frequent use of the phrase—*We worry about you*—in the advertising messages of Blue Cross/Blue Shield.

The message is directed obviously to the general population, to Blue Shield subscribers and potential subscribers. However, from my exposure to the workings of Blue Shield, to the Blue Shield Board of Directors and to the administrative staff of Blue Shield, I would have to say the phrase applies also to the physicians of Iowa.

I believe we all recognize the vital role played by Blue Shield in the delivery of health care, that through it travels much of the financial fuel to power the state's health care program. In referring to this 1970 advertising slogan, I merely wish to emphasize that Blue Shield does acknowledge the importance of the Iowa Medical Society and does worry about the service it is providing the medical profession. It recognizes that problems do exist which cause delays and make for frustration in your minds and offices. In making this acknowledgment, the officers and administrators of Blue Shield have presented an attitude and posture which seems to say: Let's get at the problems; let's use the best minds, those of able and interested physicians, lay experts and staff administrators, to resolve the many and varied problems; let's forever direct our energies to provide a more effective and efficient program of health care financing.

Involved as Blue Shield is in its own prepayment business, which now encompasses more than 900,000 subscribers; involved additionally as the private intermediary for Medicare and Medicaid, Blue Shield has many entities to which it must be responsive: subscribers, providers, government, and so forth. It has a responsibility to serve fairly and equitably the recipients and the *providers* of health care under Medicare and Medicaid. In its position as the government's intermediary, it must implement those regulatory measures which are handed down. It must do so even though at times it may question the presence of the element of fairness. On these occasions it is often the target for misdirected criticism.

What am I trying to say in these few introductory remarks? Merely this, that Blue Shield is endeavoring to do a respectable job in sometimes difficult and trying circumstances. It recognizes and accepts the fact that it cannot meet the expectations of Iowa physicians 100 per cent of the time. But, in recent years, and I emphasize this, through its Board and administrative staff, Blue Shield has demonstrated a sincere desire to work cooperatively with the officers of the Iowa Medical Society in attacking those matters which deserve attention.

To the best of our knowledge the requests of this House of Delegates have been kept in mind. When important measures, such as major contract innovations, have been contemplated by Blue Shield, they have been transmitted to the Society for study and comment prior to implementation.

We, of course, have the ever-present problem of communications. Try as we may we find it nigh onto impossible to get total understanding of a new or revised regulation or administrative procedure. We are pleased that Blue Shield is utilizing the expertise of the Medical Society in its physician information program. We urge that this be continued and extended where necessary to assure that physicians, who will read or listen, are advised to the fullest extent possible when an important procedural change is made. Let me cite an example of a recent instance where improved communications might have reduced the expressions of concern from various Iowa physicians. In January certain governmental requirements were implemented which relate to the payment of medical services under Medicare. These federal rules call for the payment of certain medical services on the basis of 1968 physician charge data; the fairness of this move is seriously questioned. Nonetheless, the action apparently had to be taken by the carrier. My point is this: With more advance information about this kind of action, it will be more willingly accepted by the medical profession.

It was my privilege to present the Blue Shield section of the 1969 report of the Board of Trustees. In that report I was pleased to remind the House of the harmonious relationship which now exists between the Society and Blue Shield. I advised the 1969 House that C. V. Edwards, Sr., M.D., of Council Bluffs, had become chairman of the Board of Directors of Blue Shield, and that S. P. Leinbach, M.D., of Belmond, had succeeded Dr. Edwards as president. These men, both of whom are past-presidents of the Iowa Medical Society, continue in these important positions. And today I have the pleasure of presenting these men to you. Very likely, their few remarks will follow the year's advertising slogan, *We worry about you!!*

First of all, I will call on Dr. Edwards, and then request that he invite Dr. Leinbach to make those remarks he wishes. Dr. Edwards.

C. V. Edwards, Sr., M.D.

Chairman, Board of Directors, Iowa Medical Service

Thank you, Dr. Wicks.

Speaking for the 25 members of the Blue Shield Board of Directors and for the 233 employees of Blue Shield, may I declare unequivocally in opening these remarks that, *We do worry about you.* It is our desire at Blue Shield, as a non-profit entity directed principally by physicians, to maintain the position of leadership we now have in the important field of health care economics. We recognize that to do this we must work closely with the medical profession. We recognize, too, we must be attuned to the times and make

those contributions we can to the complex health care delivery system.

To elaborate just a moment on the advertising theme for this year, to which we have now alluded several times: this is an attempt to further personalize our approach to the citizens of Iowa. The entire phrase being used in the 1970 advertising thrust goes like this: We *pay hospital and doctor bills, and we worry about you.* We are trying to say briefly and meaningfully that we have and will continue to demonstrate a genuine concern for those who subscribe in Blue Cross and Blue Shield.

The chief worriers, if you want to call them that, are the 25 men who serve on the Blue Shield Board of Directors. Included in this number are 18 men who are our professional colleagues. Eleven are physicians elected from geographical areas identical to the Society's Councilor Districts; the other 7 are elected at large.

To say these men oversee a large-scale financial program is an obvious understatement. As of December 31, 1969, Blue Shield subscriber contracts in force numbered 428,195. This is an increase of nearly 30,000 over 1968, and it means that over 900,000 Iowans are now receiving financial support for their health care from Blue Shield.

Dollar figures are also helpful in providing an impression of the important role played by Blue Shield. Subscriber income for 1969 amounted to just over $29 million. That paid to physicians from this total amounted to more than $24 million. The subscriber dollar is divided approximately as follows: 83 per cent in payment to physicians; 12 per cent for cost of operation; and 5 per cent for reserves. We should remember that these figures are for Blue Shield alone —Medicare and Medicaid are not included.

To give you some impression of the growth which has occurred over the years, since we are at the beginning of a new decade, the Blue Shield subscriber income in 1950 was about $2.5 million; in 1960, it was approximately $13 million; and, in 1970 it will most certainly exceed $30 million. And, of course, the payment of physician claims has followed a parallel line just under subscriber income.

What about the type of contracts or coverages represented in this rather impressive growth pattern? You may recall that the Usual, Customary and Reasonable (UCR) Contract has been a principal topic of consideration in recent sessions of the House of Delegates. As a matter of fact, the 1969 House concurred that "Blue Shield should ultimately aim at contracts which are *all* based on the UCR concept."

This request of the 1969 House has received considerable attention, and I am pleased to report that Blue Shield UCR contracts, which at this time must be placed on a group basis and must be national accounts, have increased from 1,677 at the close of 1968 to 11,487 at the end of 1969. I believe you will agree that this represents significant growth. At the same time, again in compliance with the wishes of the House of Delegates, the low level contracts have continued to be sharply reduced; this concerted reduction has been in phase since 1965 and the Series "300," "400" and "450" contracts all continued to decline in number during 1969.

Further reference to the UCR concept is definitely in order. The UCR approach was authorized experimentally by the 1968 House of Delegates. We are now coming upon two years' experience with several major national accounts, the most extensive of these being the Federal Employees Program which covers approximately 40,000 persons. The Insurance Commissioner requested two years favorable experience as a prerequisite to authorizing expansion of UCR to include intrastate groups. We believe the record will demonstrate to the Commissioner the merits of the UCR program and will result in his authorizing use of the concept on a broader basis. The presentation of this information to the Commissioner will likely be made during the summer months.

I believe it would be in our best interests to describe briefly the UCR concept. I may be guilty of repeating what has already been brought before the House. Under the UCR, charges of *all* physicians are paid on the basis of usual, customary and reasonable fee determinations.

In this respect, there is no differentiation between participating and non-participating physicians. Internal fee guidelines are established by Blue Shield on the basis of past charges submitted. These guidelines allow for the full payment of a higher percentage of claims. In addition to the internal establishment of fee guidelines, and this is very important, the peer review mechanisms of the Iowa Medical Society are utilized to evaluate specific questions which may be raised.

As the UCR contract is presumably sold to more and more state groups, we will be confronted by a need to more clearly establish the mechanisms to be used in identifying "reasonable charges." By this I mean the possible increased use of specific geographical regions within the state to determine reasonable charges; also, we feel that further attention may need to be given to the formula which is used to produce the original screening point, for example, the 96th percentile, the 90th percentile or some other figure.

As has been noted, the UCR concept eliminates the disparity between payments to participating and non-participating physicians. As you know, this is not the case in the Blue Shield Comprehensive Program. The Blue Shield subscriber who receives care from a non-participating physician under Comprehensive may be penalized in that the allowed coverage to the non-participating doctor is based on $5 per unit. Consequently, the subscriber, in these instances, may find the benefits falling short of expectation and he is obliged to pay the difference. This has caused obvious distress.

On the other hand, UCR has the virtue of eliminating the discrimination between participating and non-participating physicians. And the House of Delegates has seen fit to endorse this virtue. UCR pays usual, customary and reasonable fees to all physicians. It encourages the use of peer review where questions arise. It includes, and this is very important to bear in mind, a "hold harmless" feature which provides that the physician must agree to accept the payment of the reasonable charge and must not render a subsequent bill to the patient. If a dispute should arise, the matter must be settled between the physician and Blue Shield, using the peer review mechanism, if necessary. It is possible for a physician to arrange with his patients *in advance* a mechanism for the payment of any additional sum he feels he is due.

While the Blue Shield Comprehensive program has

continued to flourish, we do recognize and accept the fact that the Comprehensive will lessen in appeal and its long range growth will be curtailed. Blue Shield acknowledges and is willing to accept this fact. We view the two programs at this time as an effective means of further reducing the number of low level contracts and we recommend that both continue on the market. We trust the House of Delegates will concur with last year's expression of approval for the marketing of UCR coverage by Blue Shield on an intrastate basis, if and when such a move is authorized by the Insurance Commissioner.

Let me conclude my phase of this report by mentioning that these matters were reviewed in some detail at an April 15 joint meeting of the Society's Board of Trustees and the Executive Committee of the Blue Shield Board. These periodic joint sessions are most worthwhile and we intend to encourage them. Acknowledged at this meeting was the complex nature of UCR; it was the unanimous feeling of those present that care should be exercised in guiding its development.

Now, let me defer to one of the state's most respected physicians, Dr. S. P. Leinbach, President of Iowa Medical Service. He has further information about the Blue Shield program in which you should be interested.

S. P. Leinbach, M.D.

President, Iowa Medical Service

Thank you, Dr. Edwards.

Let me pick up from where Dr. Edwards left off by underscoring the importance which Blue Shield attaches to the "working-together" philosophy which has evidenced itself over the past four or five years. We are delighted at this cooperative spirit, and we see new evidences of it each year.

The Quality Assurance Program is a good example. Last year, Q.A. was in a somewhat embryonic state and considerable time was taken by Dr. Wicks to explain the program. In essence, as you know, the Quality Assurance Program has as its objective assuring the efficient utilization of health-care services and the prudent use of health dollars.

We at Blue Shield are pleased to have had the Society's expanded Peer Review Program aligned as a separate but valuable adjunct to Q.A. Blue Shield shares with the Medical Society the strong belief that Peer Review is a must in the field of medical economics. Peer Review is perhaps the most important element in medical economics for it has the potential (1) to conserve the health care dollar; (2) to educate and inform the public and the profession regarding the economics of health care; (3) to assure the appropriate use of health care personnel and facilities; and finally, and importantly (4) to preserve the high standards of medical practice in Iowa.

It may be of value, in line with tradition, to mention some of the new benefits which have been added to various of the Blue Shield coverages this past year. These have been made known to all Iowa physicians prior to their implementation. The following benefits became effective February 1:

(1) Coverage for medical emergencies. This refers to the sudden and unexpected onset of a condition requiring medical care. This is care the subscriber secures as quickly as possible, but in no case, later than 72 hours after onset. Included here are such acute conditions as cardiovascular accidents, poisonings, loss of consciousness or respiration and convulsions.

(2) Radiology and pathology services in a physician's office when such services are consistent with the condition for which the patient is surgically treated on the same date.

(3) Professional services for obstetrical care provided to dependent children under a family contract.

(4) Coverage for dependent children who are full-time unmarried students and who meet the requirements of a dependent as established by the Bureau of Internal Revenue.

Blue Shield has kept in mind the request of the House of Delegates that when new benefits and contract modifications are contemplated, they should be devised with the goal in mind of maximizing the use of outpatient and private-office facilities for diagnosis and therapy.

Let me add, too, in line with this, there have been preliminary discussions this year between representatives of the Society's Committee on Psychiatric Care and officials of Blue Shield on ways in which increased coverage of outpatient mental health care might be provided.

In the interest of increased efficiency, Blue Shield began utilizing the services of E.D.S. (Electronic Data Systems) of Dallas, Texas, on January 1. E.D.S. is now supporting Blue Shield with certain data processing services in the Medicare Part B area. This new alliance stands to increase mightily the efficiency of Blue Shield. The results have been quite dramatic even in this short time. In February, for example, more than 85,000 Medicare Part B claims were processed and $2.5 million was paid out. March provided a similar report. With the monthly input of Part B claims falling below this 85,000 level, you can see that definite strides are being made to reduce the claim backlog.

You may be interested to know that in 1969 Blue Shield paid $14.6 million in Medicare Part B claims; this is in contrast to $18 million paid in 1968. On the Medicaid side of the ledger total payments for 1969 amounted to $26.6 million, compared with $27.8 million in 1968. Thus, you can see there has been no escalation in these programs in two years. Medicaid payments to medical doctors in 1969 totalled $4.8 million, compared with $5.5 in 1968.

Before leaving Medicare and Medicaid, I must make one point crystal clear in the minds of the physicians of Iowa. The Government Programs allow no latitude to Blue Shield in determining such things as usual, customary and reasonable allowances. The formulas and timetables are prescribed by SSA. For example, SSA now regulates prevailing allowances for physicians' services at the 83rd percentile based on fees charged during calendar year 1968. Effective July 1, 1970, according to proposed legislation, prevailing rates will be changed to the 75th percentile of fees charged during calendar year 1969. Subsequent increases in future years must be related to changes in appropriate economic indexes. One very important point—Blue Shield payments under the UCR contracts are not computed on this same basis. Blue Shield payments

are computed in excess of the 90th percentile and are based on more current charge data.

Another matter to which Blue Shield will have to address itself, depending on the action of this House of Delegates, is that of Blue Shield participation by osteopaths. This will require consideration during the coming months.

You may be interested also in knowing that Blue Shield is experimenting with an arrangement which provides for the entry of procedural code numbers at the point of claims origin. This experiment is now in progress at the Cogley Clinic in Council Bluffs with the clinic personnel actually coding claims by number for Blue Shield. The pilot program is working well and is expediting the claims handling process at Blue Shield. It appears to have expansion possibilities. Broad implementation of the concept could greatly reduce the number of coding errors and also serve to refine the determination of reasonable charges.

As a member organization, Iowa Medical Service is obviously interested in the activity of the National Association of Blue Shield Plans. NABSP has taken recent action which enables it to function as the prime contractor for all Plans in dealing for Government contracts. This has been a matter of particular interest. It is an arrangement which may have virtue, but it may also pose serious questions. It is an area which deserves to be followed closely.

If I may, I would recapitulate or summarize for Dr. Edwards and myself by enumerating six objectives at which Blue Shield is aiming. They can be achieved if the present spirit of cooperation between the Society and Blue Shield remains in tact.

(1) The application of the usual, customary and reasonable concept to the greatest extent possible.

(2) The upgrading of Blue Shield subscriber coverage, and conversely, the continued reduction of low level contracts.

(3) The demonstration of a responsiveness to the demands of the market place, to include coverages for mental health, major medical, etc.

(4) The more extensive and effective use of the Quality Assurance and Peer Review to sustain ethical values and protect against abuse and over utilization.

(5) The continued effort to increase the administrative efficiency of Medicare and Medicaid.

(6) The development of a sound total program to utilize the talents of all Iowa physicians to serve the citizens of the state.

We thank you for the opportunity to submit this report. With support from Mr. Recknor and others of the administrative staff, we shall be available to furnish additional and specific information as you may desire it.

Thank you.

FINANCES—SECTION IV

Presented by Ralph L. Wicks, M.D., Trustee

(Referred to the Reference Committee on Reports of Officers.)

The 1968 House of Delegates increased IMS dues $25 per member effective January 1, 1969. With the dues increase the Society was able to meet its financial obligations in 1969 with an excess of income over expenses of $6,229.41.

Each year for several years the number of IMS dues paying members decreased. This trend was halted in 1969. Even so, the matter of non-dues paying physicians is of concern to the Board and with increased attention given to this matter by District Councilors and County Society officers we look forward to an even higher percentage of physicians becoming active dues-paying members.

As previously mentioned, the Board has explored with other state medical societies the feasibility of a "combined" scientific meeting on a regional basis. Several states have expressed interest and further discussion is to occur during the June AMA Annual Meeting.

The financial picture of the JOURNAL continues to be bothersome. The JOURNAL loss decreased from $20,000 in 1965 to $11,600 in 1967. In spite of concerted efforts to reduce costs, a decline in advertising income and an increase in expense returned the JOURNAL to a loss figure of $21,400 in 1969. As previously reported, the Board has and is exploring methods to consolidate printing and other costs—this will continue.

Early in 1970 Mr. Ed Hamilton, who had been managing editor of the JOURNAL retired from active employment. His services through the years were very valuable. The Board of Trustees has officially recognized Mr. Hamilton's many contributions. Don Neumann, who has been with the Society a number of years, is the new managing editor of the JOURNAL. This is in addition to executive responsibilities he has had in the past. As many of you may know, Don is expert in journalistic ability and in the graphic arts. The Board wants to remind the House of the long and faithful services of D. H. Kelly, Sr., M.D. We believe Dr. Kelly to be one of the outstanding scientific editors in the country. He continues as the backbone of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

It is our intent to assure Iowa physicians access to a fine medical publication meeting the needs of a modern medical organization. With this in mind, the Board asks for authority to experiment with the format of the JOURNAL in an effort to increase interest in it—to enhance its value as a public relations tool—and hopefully to correct the fiscal imbalance.

Six budget items continue to comprise approximately 80 per cent of the Society's operating expenses. These are Salaries; Building interest and principal; Committee work; Travel, both officer and employee; JOURNAL; and Taxes. Annual Sessions of the Iowa General Assembly have added to our financial burden. The involvement of organized medicine in legislative matters continues to require constant attention by your officers, committees and staff.

The accelerated payoff schedule on the building remains unchanged as suggested by the House of Delegates. Final payment is now planned for 1972.

Based on 1970 budget estimates, it appears the Society will be able to meet its commitments in 1971 with dues maintained at the present level and the Board of Trustees so recommends.

Before introducing the Chairman of the Board of Trustees to present the final section of the Board of Trustees' Report, I want to quote from an issue of U. S. NEWS & WORLD REPORT that comments on Senate Finance Committee findings and contemplations relating to the future of Medicare and Medicaid:

"The key to making the present system workable and acceptable is the physician and his medical socie-

ty. We are persuaded that at this point in time neither the Government nor its agents have the capacity to effectively audit medical practice to assure that a given physician functions responsibly in dealing with the publicly financed programs.

"While there is growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance has been spotty and isolated so far. Prompt action is necessary by organized medicine (and other health-care professions) to do what is required with respect to monitoring care provided and charges made for the care. In the absence of such constructive effort, we fear that virtually insurmountable pressures will develop for alternative control procedures which may be arbitrary, rigid and insensitive to the legitimate needs of both the patient and his physician."

Dr. Lister will now present a new and intriguing concept in health care financing.

FOUNDATION FOR MEDICAL CARE—SECTION V

Presented by Kenneth E. Lister, M.D.
Chairman, Board of Trustees

(Referred to the Reference Committee on Reports of Officers.)

A careful review of the record of the Iowa Medical Society as it relates to the beginning of third party payment for physician services indicates a posture of logical response.

It responded to a universal health insurance scheme in the mid-forties by the creation and sponsorship of Blue Shield.

It assumed responsibility in promoting private health insurance in various forms. It took an active part in negotiating contracts with the Veterans Administration to provide hometown care for returning servicemen.

In more recent years, it provided its expertise in the implementation of a military dependents program—Kerr-Mills legislation, Medicare and Medicaid. Admittedly, it was with less than great enthusiasm that the Society became involved in the intricacies of Medicare, a plan it believed unnecessary, premature, and a departure from an established policy of providing comprehensive health care for those in need.

These developments have contributed to an evolution in the delivery and financing of health care—good, bad or indifferent. We are at the point of having to evaluate the Society's position *vis-à-vis* all of the various financing mechanisms, but specifically Medicare, Medicaid and the more recently announced health maintenance organization concept. The latter proposal, if enacted by Congress, would permit eligible recipients to choose between care provided on an individual physician basis or closed panel plan similar to Kaiser-Permanente.

In recent months, several state medical associations have created "foundations for medical care" patterned after those existing in San Joaquin and San Diego, California. These foundations came into being in the mid-fifties to meet the competition of the closed panel programs.

States now in the process of setting up foundations for medical care include New Mexico, Colorado and Georgia.

In brief, a foundation for medical care administers various systems such as peer review, utilization review and in some instances, claims processing, for governmental and private third parties, on a contractual basis.

The AMA Newsletter that emanates from the office of the executive vice president of the American Medical Association states that "the major motivational factor behind the medical society explorations of establishing foundations for medical care is a desire that the profession take direct responsibility for overseeing services provided by its members. The medical societies believe they can stimulate greater physician interest and involvement in providing services under Medicaid, fulfill a professional obligation to provide quality medical care as economically as possible, and assure that services are being properly utilized."

The director of the AMA Law Department has stated his personal opinion that medical foundations of the type now coming into being provide objectivity once removed from the intricacies of the operation of a medical society, and avoid other complications and involvements, such as internal politics, etc. He believes in the process of establishing a foundation for medical care and, in light of the times, that serious consideration be given to including a limited number of prominent laymen on the boards of directors of these foundations. However, he also offers a strong admonition that these foundations, in the main, must be guided by essentially the same people as those responsible for the day-to-day affairs of the sponsoring medical society.

In order to demonstrate further the interest in the "Foundation" approach, I quote from a report on "Health Care Delivery in the 1970's" which was developed by a subcommittee on Health Care Delivery of the Committee on Medical Economics, Health Insurance Association of America, and approved by that association:

". . . greater effort should be exerted and support given to the Health Insurance Council in the development of a practical and workable system of peer review, including a review of both professional fees and utilization; and that where such review functions well, insurance companies make maximum use of such facilities. . . . This recommendation is made in view of the considerable opinion expressed to the subcommittee that private insurers should exert strong and direct influence on the price and utilization of health services. There are those who advocate an organized approach by third-party payors, both private and public, by which fees and payments would be negotiated through bargaining with the providers of care, perhaps employing the 'foundation' approach."

The following recommendation was also approved by the Health Insurance Association:

"That because there are several types of laws among the states which regard or even restrict needed developments in present health care systems, the Association assume the initiative by calling a meeting of lay leaders and professionals to identify such restrictive statutes and plan a course of action to bring about needed change; and that the Association actively support soundly conceived efforts to improve present laws. . . . Several types of existing state laws impede needed development in health care systems and should be changed in the interest of progress. These include: laws in several states which prohibit the development of group practice plans. These should be repealed."

There is evidence that an increasing number of nonprofit prepayment organizations are directing their attention to the group-practice concept which would involve physicians entering into contractual arrangements to provide comprehensive medical care on a fixed fee basis.

Even though public attitude and political climate are undergoing drastic changes in reference to the delivery and financing of health care, we are dedicated to resistance to those programs we believe are not in the public interest and complete support for those that are.

However, if we are to anticipate what may occur and be prepared to act, not react, should group practice of the closed panel type become real in Iowa, then we must have available those mechanisms that will provide the greatest flexibility and mobility for organized medicine to meet these new circumstances.

Should a universal health insurance program be enacted by Congress, it is suggested its form will include standards or criteria of coverage which, if met, would permit a number of underwriters to participate. If this occurs, medicine would need a negotiating instrument capable of entering into contractual agreements with all of the underwriters, but each separately to provide the most acceptable financing systems for the services provided by physicians and to maximize quality and quantity medical care.

The Board of Trustees has not had the time nor the opportunity to study the Foundation concept in depth. However, officers of the Society have learned a great deal about the function and structure of the Foundation approach during programs at both the North Central Medical Conference held in St. Paul last fall, and at the AMA Interim Meeting in Denver last December. We have obtained information from the established Foundations in California, and also from states which are moving in this direction, specifically New Mexico and Colorado.

Based on the information we have reviewed, it is a consensus of the Board that it behooves the IMS to consider the pros and cons of creating a Foundation for Medical Care in Iowa that could assume responsibility for entering into contracts with any legitimate third party desiring its professional services.

Specifically, the Board of Trustees respectfully seeks authority from the House of Delegates to:

1. Continue with an in-depth feasibility study of establishing a Foundation for Medical Care in Iowa, including all of the ramifications—legal and otherwise —that such a project would entail.

2. Schedule a series of meetings throughout the state to familiarize all members of the Society, but especially the delegates, with information about the structure and operation of a Foundation for Medical Care.

3. Submit definitive recommendations regarding the creation of a Foundation for Medical Care in Iowa to the House of Delegates, in special session, no later than the fall of 1970.

A Conference of Medical Care Foundations will be held in California the latter part of May. A major part of the program will be devoted to the discussion of basic operations and objectives of Foundations, especially with respect to peer review, utilization and quality of care. If the House of Delegates responds favorably to the recommendations of the Board of Trustees, representatives of the Society will attend the Foundation Conference next month.

This concludes the reports of the Board of Trustees. We thank you for your attention and indulgence.

Kenneth E. Lister, M.D., Chairman of the IMS Board of Trustees, next presented a check in the amount of $11,474.66 to Robert Hardin, M.D., Vice President of Health Affairs, University of Iowa. The check was presented on behalf of the American Medical Association Educational Research Foundation. Dr. Hardin spoke briefly acknowledging the gift and asked for permission to introduce two colleagues, John W. Eckstein, M.D., and John C. MacQueen, M.D.

DR. ROBERT HARDIN

Thank you very much, Dr. Lister.

As I have said often from this podium, funds of this type are important for two reasons: 1) they come from the profession, and 2) they come with no strings. I am sure that the officers of the College will find these funds as useful as they have in the past.

Today I appear before you in a rather different role than I have before. As you know, last September, I was asked by our new President to assume broader responsibilities in the central administration of the University, which meant that I had to leave the College of Medicine. So, at that time Dr. Rieke, who is head of the Department of Anatomy, assumed the Office of Dean of the College on a pro tem basis, and some of you have met and worked with him since then.

The Search Committee began the job of looking for a dean for the Medical School. As you know, one has been chosen who will assume office on June 1.

I would like to say that, in my tenure as Dean, one of the most enjoyable things was the warm relationship which I had as a person and which the School had as an institution with the Iowa Medical Society. We have enjoyed your firm support; we sought your advice. And I think we have a relationship which perhaps is somewhat unique in this country, because as I travel around I do not find this kind of relationship in all states. I know that the new officers of the College wish to continue that relationship. It is more important now, perhaps, than it has ever been, as medical education and the practicing segment of medicine look forward into the problems of the next few years, as has been alluded to from this platform this morning. And I assure you that medical education faces some tremendous problems which are related to those problems you find yourselves facing in practice. It is more important now that we do have a close liaison and that we do work together.

To that end, I would like to say that I would personally like to keep my relationship with the Society but, in addition to that, there must be a very close relationship between you and your new Dean of the College of Medicine. I know that he is anxious to have that relationship.

I should like at this time to have the privilege of introducing Dr. John Eckstein who will become Dean of the College of Medicine on June 1. I would like him to come forward, please.

Dr. Eckstein is a product of our own school; he is a product of Iowa. His father was a general practitioner

in Iowa. He is a well known scientist in the field of cardiovascular disease. He has, fortunately for us, become interested in administration. Dr. Eckstein.

DR. JOHN W. ECKSTEIN

I am pleased to have the opportunity to appear before you. I would like to read a portion of a statement which I made to the faculty a few days ago. This statement expresses some of the thoughts which I had in connection with the deanship and they may be of some interest to you.

"I am accepting the deanship with full awareness of the many problems which the College faces. The growth which we have experienced during the past decade because of almost unlimited federal support has leveled off and income from a number of sources is beginning to decrease. Our whole system of training health personnel is under criticism and we must make changes. Our plans for educating physicians require re-evaluation. Family Practice, Environmental Health, Community Medicine, Rehabilitation, Allied Health, Paramedical Programs of all sorts, and Programs in Continuing Medical Education demand our attention. I am not suggesting that we must do something about all of these things now, but we must be concerned about these matters and we must make plans to deal with them. We will feel the effects of financial constraints during the coming year and we will find it difficult to respond to the needs and pressures for these new and different programs.

"Despite my concern about financial matters I am aware of the many strengths of our College. We have a fine record of accomplishment and a fine tradition. We owe much to our alumni and the people of Iowa who have supported us. We are part of a great university. We have an outstanding faculty and student body, fine hospitals, a good building program and a good base of support when we are compared with many medical schools.

"During the past few weeks I have had many discussions with faculty members from many departments, and I sense an attitude of interdepartmental cooperation and a feeling of collegiate responsibility which is much deeper than I had realized. Many faculty members have offered to take on significant extra assignments to help in the development of our programs. I an confident that with this kind of faculty cooperation and leadership we will weather the financial constraints of the next few years and emerge in a much stronger position than we occupied during the immediate past period of rapid growth."

Since my appointment was announced on April 9 I have received telephone calls and notes expressing encouragement and support from many physicians throughout the state. I was especially pleased to receive a very warm letter from the President and Officers of the Iowa Medical Society.

I would like to assure you that the administration and the faculty of the College of Medicine expect to continue the close ties with the Iowa Medical Society that existed during Vice-President Hardin's tenure as Dean of the College. We are proceeding with the Family Practice Department. I have not yet met with the Committee appointed by Dean Rieke so there is little that I can report except to say that I fully support this effort and that I expect a good department. We do intend to put extra emphasis on programs of continuing medical education, especially those designed for the general practitioner. Dr. Richard Caplan will be spending more time in this area during the coming year and we want to know from you the types of programs that you believe to be most beneficial. Dr. Caplan will be here throughout the meeting. I hope all of you will have a chance to visit with him and give him your thoughts.

Another area of particular interest to me is the use of community hospitals for some of our teaching programs. Medical education is in a process of change and much is being said now about directing our educational efforts outward. Development of affiliated programs is a complicated matter which will require much thought and planning by both community-based physicians and physicians based in the College of Medicine. I believe, however, that we should begin to get experience in community hospital affiliations, and I hope that we can make some effective moves in this direction as resources become available.

Again let me say that I expect to maintain close ties with the Society and with physicians throughout the state. I hope that we can work together effectively for many years.

DR. JOHN C. MacQUEEN

This Medical Society knows that the question of creating a Department of Family Practice has been discussed by members of this Society and by members of the faculty of the College of Medicine for several years.

The College has been acutely aware of a broad based interest in the creation of the Department of General Practice. In fact, there have been many problems in the way of creating such a department. Not the least of these problems has been the difference, the honest difference, of opinion as to what constitutes general practice. Without an agreement as to the definition, it has been difficult to determine what the content of the program should be, who should teach it, where the program should be conducted. These problems have been general. They are reflected in the fact that up until the present time very few departments of general practice existed in the country.

In November, 1966, the AMA House of Delegates approved the recommendations of the report of the Ad Hoc Committee on Education for Family Practice and directed the Council to develop and initiate plans for implementing the recommendations.

The Council on Medical Education has approved the committee report entitled "Special Requirements for Residency Training in Family Practice." This was done in concurrence with the American Academy of General Practice and the AMA Section on General Practice. The requirements were approved by the AMA House of Delegates in December 1968.

It is now important to note that this new specialty, family practice, was able to profit by the experience of the other specialties and is now presented to the medical education community with more and better guidelines for program development than any other specialty.

Of particular importance to us is that the specialty has a name; it is *Family Practice.* It is of importance that the family practitioner has been defined. Many of you know it but I will read it because I think it is important that we hear the words:

"A family practitioner is one who serves as the physician of first contact with the patient and provides a means of entry into the health care system; evaluates the patient's total health needs, provides personal medical care within one or more health fields of medicine, and refers the patient, when indicated, to appropriate sources of care while preserving the continuity of his care; develops a responsibility for the patient's total care, including the use of consultants, within the context of his environment, including the community and the family or comparable social unit. In short, the family physician must be prepared to fill a unique and special functional role in the delivery of modern comprehensive health service."

This is the charge to us, to develop a program that will train such a person. Furthermore, the essentials for developing this program include recommendations about just everything: the duration of training, the content of the training, what type of model will be used for the training, who shall teach the trainee, the content of undergraduate program.

In addition, the Commission on Education of the American Academy of General Practice has created a very active and effective staff to consult with developing programs.

As a result of this fine effort, there are now 55 programs of family practice in the United States, either operating or well along in planning. It is a remarkable growth in a short period of time and reflects the great effort that has been put into it.

During the last year the University of Iowa College of Medicine has responded to these developments and moved to re-evaluate the possibility of creating a Department of Family Practice.

The faculty Committee on Medical Curriculum considered the introduction of the ingredients of this program into the curriculum and reported favorably. An ad hoc committee of the faculty conducted a comprehensive feasibility study and reported favorably.

The question of developing a Department of Family Practice was presented to and discussed by a special faculty meeting and (the faculty) was overwhelmingly in favor of creating a department.

The recommendation was made to the Board of Regents on January 15 and approval was given for the development of a department. I would read very briefly to you from the summary statement that was made in that proposal, for I think there are some ideas here that are important.

"The department will have its administrative office and principal undergraduate educational programs in Iowa City. It will have equal administrative status with all other departments in the College. As a University department, it will conduct research in family practice; it will develop and coordinate both undergraduate educational and graduate programs. In so doing it will employ not only Iowa City facilities but also those at Broadlawns Hospital in Des Moines. Other possible sites in the state may also be utilized.

"Existing fiscal and physical resources will be used to initiate the department immediately upon its authorization. Feasibility studies indicate that the department can attract faculty and students.

"The overwhelming support demonstrated by the College of Medicine faculty and administrators during recent meetings devoted to this proposal augur well for the success of the new Department of Family Practice."

On the basis of this report, the Board of Regents responded favorably. Actually, the College of Medicine has completed a year's homework on this matter, so we are well into the developmental stage.

On February 9, Dean Rieke appointed a Search Committee to recruit a chairman for the department. The committee has been active; it has met with the President of the Iowa Academy of General Practice and with a field representative of the Commission on Education of the American Academy of General Practice. It has developed a list of qualified people who have indicated an interest in this position. The committee is moving with due haste and the appointment should be made in the foreseeable future.

The wheels of medical education turn slowly but they do turn, and they are responding to the need for changes in the American medical education system. One of these is the creation of a Department of Family Practice.

Dr. Hardin concluded the comments of the College of Medicine representatives by extending personal thanks for the support given him by the Medical Society. He expressed pleasure over developments at the College and indicated he was looking forward to working with Dean Eckstein.

INFORMATIONAL REPORT ON THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

Kenneth E. Lister, M.D.

President, Scanlon Medical Foundation/Iowa Medical Society

It is my pleasure to present this 1970 report of the Scanlon Medical Foundation/Iowa Medical Society. You will recall late in 1968 the name of the Foundation was changed from Iowa Medical Foundation to Scanlon Medical Foundation/Iowa Medical Society. This unanimous action by the Board of Directors was taken to honor the late Dr. George H. Scanlon, the man most responsible for the establishment and growth of this instrument of the medical profession.

Growth is an appropriate word too, for the Foundation has experienced considerable growth in service capability and in financial strength during its 18 years. This growth has been evident in 1969 and 1970.

While I am guilty of some repetition, you should be reminded that the Scanlon Medical Foundation/Iowa Medical Society is a non-profit corporation. It exists, as stated in the Articles of Incorporation, to engage in, assist, further, promote and contribute to the support of such charitable, educational and scientific activities and projects as are, in general, either directly or indirectly, related to health or medicine.

I am pleased to advise that a well-qualified and interested group of men comprise the Foundation's Board of Directors. The Foundation Board includes nine persons: J. F. Paulson, M.D., Mason City; R. E. Wicks, M.D., Boone; C. W. Seibert, M.D., Waterloo; R. F. Birge, M.D., Des Moines; L. H. Jacques, M.D., Iowa City; E. Howard Hill, Minburn; Ronald F. Saf, Des Moines; Donald L. Taylor, Des Moines, and yours truly. Mr. Saf, who is an attorney and executive sec-

retary of the Iowa State Board of Medical Examiners, was elected to membership on the Board at the last Annual Meeting.

This Board of Directors, will hold its Annual Meeting at the Hotel Fort Des Moines tomorrow afternoon, and at that time the activities of the Foundation will be reviewed in some detail.

The Foundation's program has received continued good support during the past 12 months. This support, as you know, comes principally from the medical profession, either from individuals or organizations. We have attempted to identify the Foundation as an ideal means of memorializing a colleague, and a number of physicians are now using the Foundation for this purpose. We have also made an effort to encourage county medical societies to contribute or loan monies to the Foundation whenever their treasuries will permit, and this too has been a pattern adopted by several such groups. For example, I would like to acknowledge publicly recent action of the Iowa Association of Pathologists in entrusting $2,000 of its funds to the Foundation. Also, the Woman's Auxiliary to the Iowa Medical Society, the Appanoose County Medical Society, the Lee County Medical Society and the Cerro Gordo County Medical Society are other organizations which this year have either given or loaned funds to the Foundation or have supplemented existing loans.

You will notice on the 1969 Income and Expense Statement, which is included with this report, that Foundation income from the several sources noted amounted to $34,661.15. This is more than double the amount reported for 1968. Also, on the accompanying Balance Sheet, the heading *Notes Payable to Physicians* will identify for you the monies on loan to the Foundation from individual physicians and medical organizations. This increased during 1969 by approximately $3,000 and now totals just over $49,000. Thus, the combination of these two sums ($34,661.15 and $3,000) reveals financial activity in 1969 in excess of $37,000.

At the same time, the Foundation has been actively getting this money into productive use. Using a slightly different and more up to date 12-month interval, the Foundation has loaned $32,455 to medical students between April 5, 1969 and March 31, 1970. This is believed to be the largest sum of money ever loaned by the Foundation in a period of 12 months.

Medical student candidates for the Foundation's general practice loans have been plentiful. This is due in part to the recent drying up of other sources of financial assistance. As you may recall, under the general practice program the Foundation is empowered to make loans of up to $2,000 to sophomore medical students who will agree to enter general practice in Iowa for at least three years. The loans are renewable for the junior and senior years.

There are now 18 medical students receiving Foundation loans and virtually all of them are active in the general practice phase of the loan program. Incidentally, I might mention that last October the Foundation Board met in Iowa City, and as part of that meeting the Board hosted a group of those medical students who are participating in the loan program. Speaking for the members of the Board, I might say that we were most impressed by the interest, enthusiasm and bearing of these students. They were indeed topflight appearing young men. Also present on this occasion were Mrs. George Scanlon; Miss Gladys Manning and Mr. W. W. Summerwill of the Iowa State Bank and Trust Company; and W. W. Morris, Ph.D., Associate Dean, University of Iowa College of Medicine. The Iowa State Bank assists the Foundation most ably with the Iowa City administration of the loan program. And Dr. Morris counsels the medical students on matters pertaining to financial aid, and in this way serves the Foundation in a liaison way.

You may be interested in one or two additional statistical figures on the Foundation loan program. There is now on loan to active medical students more than $52,000. Since the program began some 18 years ago 238 medical students have received loans totalling almost $370,000. Of the loans made, 133 have been paid in full and 105 have a balance outstanding.

It has been generally agreed by the Board that the loan program should remain the primary activity of the Foundation. The Board has discussed the desirability of branching out into other areas of manpower recruitment, health care delivery, etc. No specific projects have been authorized but several ideas are being explored.

The Foundation is now involved to a modest degree in a public health project, that being the statewide rubella eradication program. At the request of the State Department of Health, the Foundation agreed last fall to serve as the repository for funds contributed for the purchase of rubella vaccine. A letter of agreement was consummated with former Commissioner of Health James F. Speers, M.D., and covers this joint administrative effort. For your information, the Foundation has received in the special account $254,000 for the purchase of rubella vaccine, and as of this date, we have paid $159,000 from this sum for vaccine. One stipulation in the aforementioned agreement is that any monies remaining in this special fund which are not needed for the purchase of vaccine may be used by the Foundation in line with its articles and by-laws. In addition to serving as the repository for rubella funds, the Foundation contributed $1,000 from its resources to aid in the rubella eradication effort.

May I mention briefly other activities in which the Foundation has been involved this past year. They include: (1) Participation as a co-sponsor of the recent twelfth annual Hawkeye Science Fair; (2) Participation in the 1970 IMS Annual Meeting as sponsor of The Baldridge-Beye Memorial Lecture to be presented Monday at 10:30 a.m.; (3) Participation as an exhibitor at the annual "Hall of Health" public education project at the 1969 Iowa State Fair; (4) Participation in support of the program of the Health Planning Council of Iowa; (5) Participation in part through the generosity of The Prouty Company of Des Moines, in the educational program of the Iowa Chapter of the Student American Medical Association; and (6) Participation in the Joint Wrestling Weight Determination Research Project of the IMS, Iowa High School Athletic Association and the University of Iowa.

We are pleased to have with us this morning two student representatives from the University of Iowa College of Medicine. It has been a custom of the Foundation to have medical student representatives present at the session and to recognize them. Both students here this morning are Scanlon Foundation Scholars; by that I mean they are both loan recipients. I should like to conclude this report by having you meet Mr. William E. Hicks and Mr. Mark Messingham.

SCANLON MEDICAL FOUNDATION
IOWA MEDICAL SOCIETY

Summary of Student Loan Program

Total loans entered into since inception of program	$369,162.52
Loans repaid	196,381.16
Loans outstanding as of March 31, 1970	172,781.36
Number of students who have participated	238
Number of loans paid in full	133
Number of loans outstanding	105

SCANLON MEDICAL FOUNDATION/
IOWA MEDICAL SOCIETY

BALANCE SHEET—DECEMBER 31, 1969

ASSETS:		
Central National Bank & Trust Company	$ 6,062.06	
Iowa State Bank & Trust Company	6,052.36	
Treasury Bills	49,026.50	
Notes Receivable from Medical Students	167,669.36	
Student Nurse Loan Fund	3,701.63	
100 Shares of American Scientific Corp.	60.00	
		$232,571.91
LIABILITIES AND NET WORTH:		
Notes Payable to Physicians		$ 49,026.63
Note Payable to IMS		$ 2,000.00
Net Worth:		
Balance 1-1-69	$162,950.07	
Add 1969 Gain	18,595.21	$181,545.28
Total Liabilities and Net Worth		$232,571.91

SCANLON MEDICAL FOUNDATION/
IOWA MEDICAL SOCIETY

Income and Expense Statement—December 31, 1969

INCOME:			
Contributions and Memorials		$ 12,902.50	
Henry Albert Trust		7,000.00	
Interest on Loans		7,232.71	
Interest on Treasury Bills		2,475.94	
Special Gifts:			
George H. Scanlon Foundation	$2,500.00		
Abigail Van Buren Honorarium	500.00		
The Prouty Company	250.00		
Appanoose County Medical Society	300.00		
Lee County Medical Society	500.00	$ 4,050.00	
			$ 33,661.15
EXPENSES:			
Administrative Expense (Iowa State Bank & Trust)		$ 300.00	
Interest Paid to Physicians		2,495.12	
Hawkeye Science Fair		3,250.00	
Health Planning Council of Iowa		2,000.00	
Iowa Chapter, Student AMA		500.00	
News Supplement, State of Health Care in Iowa		1,000.00	
Rubella Eradication Program		1,000.00	
Baldridge-Beye Lecture (IMS Annual Meeting)		211.59	
IMS Annual Meeting Exhibit		10.50	
Iowa State Fair Exhibit		218.21	
Office Supplies & Miscellaneous Administrative Expense		642.72	
Postage		317.46	
Salary Allotment		2,600.00	
Tax Return		50.00	
Travel and Meeting Expense		470.34	
			$ 15,065.94
Net Gain for 1969			$ 18,595.21

(Mr. Messingham addressed the House briefly and expressed appreciation on behalf of the Foundation loan recipients.)

At this point, Dr. J. F. Bishop, Chairman of the IMS Judicial Council, explained to the House that on April 15 the Judicial Council reviewed Resolution No. 16 introduced by the Des Moines-Louisa County Medical Society requesting hyphenation of the two societies. Because of the noncontroversial nature of the resolution, Dr. Bishop explained the Council recommended its approval on April 15. Unanimous consent was given by the House to a recommendation that the Council not meet as a reference committee and that a recommendation in favor of the resolution be submitted to the House on Wednesday, April 29.

Supplemental Reports of Standing Committees

NOMINATING COMMITTEE

The Nominating Committee of the Iowa Medical Society met on Sunday, March 22, and agreed upon the following slate to be presented to the House of Delegates today.

President-Elect	L. J. O'Brien, M.D., Fort Dodge
Vice President	L. F. Frink, M.D., Spencer H. R. Hirleman, M.D., Cedar Rapids
Speaker of the House of Delegates	L. D. Caraway, M.D., Monticello
Vice Speaker of the House of Delegates	Homer Skinner, M.D., Carroll
Trustee (3 year term)	R. L. Wicks, M.D., Boone A. J. Havlik, M.D., Tama
Delegate to AMA (2 year term) (Two to be elected)	L. W. Swanson, M.D., Mason City H. J. Smith, M.D., Des Moines (Terms expire December 31, 1970)
Councilor, 1st District (3 year term)	C. L. Kelly, Jr., M.D., Charles City
Councilor, 4th District (3 year term)	H. E. Rudersdorf, M.D., Sioux City
Councilor, 6th District (3 year term)	G. A. Fry, M.D., Vinton
Councilor, 11th District (3 year term)	Hormoz Rassekh, M.D., Council Bluffs
Blue Shield Liaison Delegates to IMS (Two to be elected)	C. L. Kelly, Jr., M.D., Charles City C. W. Seibert, M.D., Waterloo S. P. Leinbach, M.D., Belmond R. C. Larimer, M.D., Sioux City

Additional nominations may be accepted from the floor after which the Speaker of the House of Delegates will declare nominations closed.

The Articles of Incorporation and By-Laws require that for candidates to be unopposed for nomination they must be unanimously approved by the Nominating Committee. Although it is recognized that it is desirable to have two candidates as a minimum for each of the proposed offices, the Nominating Committee is submitting but one candidate for some offices, since these were the only names formally proposed to the Nominating Committee and were unanimously approved by the Nominating Committee.

It will be noted that there are four candidates for the two offices of Blue Shield Liaison Delegate to the Iowa Medical Society. Under the Articles of Incorporation and By-Laws of the Iowa Medical Society, the Liaison Committee shall submit to the Nominating Committee the names of four or more candidates for the two positions of Liaison Delegate. Therefore, un-

der the IMS By-Laws, it is mandatory that four or more names be submitted to the Nominating Committee for these offices. These names are merely received by the Nominating Committee and submitted as a part of its report to the House of Delegates.

Respectfully submitted,
J. F. BISHOP, M.D., *Chairman*
R. S. JAGGARD, M.D.
J. T. MANGAN, M.D.
L. K. YATES, M.D.
J. L. GARRED, M.D.
E. E. LINDER, M.D.
C. D. ELLYSON, M.D.
J. E. TYRRELL, M.D.
J. R. SCHEIBE, M.D.
R. W. BOULDEN, M.D.
M. E. OLSEN, M.D.

Nominations from the floor were requested, but none were presented. The Report of the Nominating Committee was adopted as presented.

NECROLOGY COMMITTEE

(The Speaker asked the members of the House of Delegates to rise while Dr. E. E. Gamet, secretary of the Judicial Council, read the names of members of the IMS who had died during 1969. The list appears on page 455 of this issue of the JOURNAL.)

COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

The 1969 IMS House of Delegates adopted two recommendations which would (1) create a new Councilor District consisting of Polk-Warren Counties and (2) recommend changes in the IMS Articles of Incorporation and By-Laws to permit some type of membership in the IMS and component societies for qualified osteopaths. The Committee on Articles of Incorporation and By-Laws in consultation with other appropriate Committees and individuals has considered what changes in the Articles and By-Laws are indicated to implement the intent of the House of Delegates.

The Committee first considered the creation of a new Councilor District. The Committee also concerned itself with what election procedures would be required to fill any new Councilor office. Because of these considerations the Committee is recommending that the new Councilor District (District 12) be composed of all counties presently in Councilor District 5 with the exception of Polk and Warren Counties. Polk and Warren Counties would remain as Councilor District 5. This would enable the present Councilor for District 5 to continue to serve in that capacity and would result in the Board of Trustees having to fill only one Councilor vacancy (District 12) to serve until the next regular election in 1971. Attached are Exhibits A-1, A-2 and A-3 which, if adopted, will implement the creation of a new Councilor District 12.

EXHIBIT A-1

Resolved, That the amended and substituted Articles of Incorporation of the Iowa Medical Society, as amended, be and hereby are further amended as follows:

(1) By deleting "eleven" from Article IV, Section 1, and substituting therefor "twelve";

(2) By deleting the fourth sentence of Article IV, Section 2 in its entirety, and substituting therefor the following sentence:

"The Councilors shall be elected for terms of three years each, so arranged that the terms of four Councilors shall expire every three years."

(3) By deleting "eleven" from the first sentence of Article IV, Section 5, and substituting therefor "twelve";

(4) By deleting "eleven" from the first sentence of Article IV, Section 15, and substituting therefor "twelve"; and

(5) By deleting "six" from the fifth sentence of the second paragraph of Article IV, Section 15 and substituting therefor "seven."

EXHIBIT A-2

Resolved, That the amended and substituted By-Laws of the Iowa Medical Society, as amended, be and hereby are further amended as follows:

(1) By deleting "11" from the second and third sentences of Chapter IV, Section 2, and substituting therefor "12" in each such sentence; and

(2) By deleting "eleven" from the first sentence of Chapter V, Section 14, and substituting therefor "twelve."

EXHIBIT A-3

Resolved, That Councilor District V be divided into two Councilor Districts, one of which shall be called Councilor District V and consist of Polk and Warren Counties, and the other one of which shall be called Councilor District XII and shall consist of Boone, Calhoun, Dallas, Greene, Guthrie, Hamilton, Story and Webster Counties.

In reviewing the Articles it was found that the Society still lists its principal place of business as "Des Moines." The Committee is recommending that the Articles be amended to list the correct location as "West Des Moines." (See Exhibit B.)

EXHIBIT B

Resolved, That the amended and substituted Articles of Incorporation of the Iowa Medical Society, as amended, be and hereby are further amended by striking from Article I the term "Des Moines" and inserting in lieu thereof the term "West Des Moines."

In considering changes in the By-Laws to permit membership for qualified osteopaths the Committee reviewed every page of the By-Laws where the term "physician" presently appears to determine the exact effect of any proposed change. Originally the Committee felt that it would be preferable not to include in the Articles and By-Laws the term "osteopathic physician and surgeon." However, in considering appropriate amendments and following exhaustive research the Committee is recommending amendments which would use the term "osteopathic physician and surgeon." The complexity of any other approach left the Committee with little alternative. Based on its review, the Committee recommends the adoption of Exhibits C-1 and C-2, which would permit membership in the IMS and component societies for qualified osteopathic physicians and surgeons.

EXHIBIT C-1

Resolved, That the amended and substituted Articles of Incorporation of the Iowa Medical Society, as amended, be and hereby are further amended as follows:

(1) By deleting "holding a degree of Doctor of Medicine or Bachelor of Medicine and possessing a valid Iowa license to practice medicine or surgery or to practice as a resident physician"; from Article III, Section 1, and substituting therefor "and resident physicians licensed in Iowa";

(2) By deleting "to practice medicine and surgery who hold a degree of Doctor of Medicine or a Bachelor of Medicine" from Article III, Section 2; and

(3) By adding a new Section 6 to Article III as follows:

"Section 6. 'Physician' as used in the Articles and By-Laws of this corporation shall include physicians and osteopathic physicians and surgeons who hold valid and unrestricted licenses to practice medicine and surgery or osteopathic medicine and surgery. 'Profession' as used herein shall mean the nonsectarian practice of medicine and surgery or osteopathic medicine and surgery by 'physicians.'"

EXHIBIT C-2

Resolved, That the amended and substituted By-Laws of the Iowa Medical Society, as amended, be hereby and further amended as follows:

(1) By deleting "medicine" from the first sentence of Chapter I, Section 6; and

(2) By deleting Chapter 1, Section 7 in its entirety and substituting therefor a new Section 7 as follows:

"Section 7. Resident physician membership in this Society shall consist of those practitioners who have a valid Iowa 'Resident Physician License' or a valid Iowa 'Resident Osteopathic Physician and Surgeon License,' who are members in good standing of the component medical societies, who have been so certified at the headquarters of this Society and who have been approved by the Judicial Council. They shall not have the right to vote or to hold office."

During the past year the Society appointed an Ad Hoc Committee on Medical Student Membership. That Committee was charged with the responsibility of making recommendations with respect to the feasibility of admitting medical students at the University of Iowa College of Medicine to active membership in the Iowa Medical Society. That Committee submitted to the Committee on Articles of Incorporation and By-Laws the following recommendations:

1. That the Articles of Incorporation and By-Laws of the IMS be amended to provide for the creation of a component medical society of the IMS, to be known as the "Iowa Student Medical Society," which will serve as the mechanism for making active membership in the IMS available to students at the University of Iowa College of Medicine.

2. That in order to become a member of the IMS, through the component society, the student should be required to pay membership dues. An amount of $20.00 was proposed as yearly dues, although it was acknowledged that specific recommendation in this regard would be made by the Board of Trustees to the House of Delegates.

3. That once the dues obligation has been satisfied by a medical student, he will have all rights and privileges of any active physician member of the IMS, including appointments to standing and special committees, but excluding the right to hold office.

4. That representation in the House of Delegates be determined on the basis of one delegate for every 25 dues paying members, or major fraction thereof.

Based on these recommendations the Committee on Articles of Incorporation and By-Laws submits to the House of Delegates Exhibits D-1 and D-2, which if adopted, would result in medical students holding active membership in the Iowa Medical Society.

EXHIBIT D-1

Resolved, That the amended and substituted Articles of Incorporation of the Iowa Medical Society, as amended, be and hereby are further amended by adding the following sentence to Article III, Section 1:

In the event the Bylaws shall provide some form of membership for students in good standing at the Medical School of the University of Iowa, a separate component society shall be formed whose membership shall consist solely of such student members.

EXHIBIT D-2

Resolved, That the amended and substituted By-laws of the Iowa Medical Society, as amended, be and hereby are further amended as follows:

(1) By deleting Chapter 1, Section 1 in its entirety and substituting therefor the following new Section:

SECTION 1. Membership in the Iowa Medical Society shall consist of Active, Life and Associate Members as defined by Article III of the Articles of Incorporation and also of Resident Physician members, student members and honorary members. The official roster of members shall be maintained at all times in the office of the Secretary. It shall be composed of the names of those physicians, student members or honorary members certified to the executive office of this Society as provided for by Chapter VI of these By-Laws, and duly approved by the Judicial Council. Registration of the name of a physician, student member or honorary member upon the official roster shall be *prima facie* evidence of his membership, and his right to the privileges inherent in that membership."

(2) By renumbering Chapter I, Section 8 as Section 9 and inserting a new Section 8 in Chapter I providing as follows:

"Student membership in this Society shall consist of those students in good standing at the School of Medicine at the University of Iowa who are members of the component society authorized to be established for such students, who have been so certified to the headquarters of this Society and who have been approved by the Judicial Council. They shall have the right to vote but shall have no right to hold elective office in the Society."

(3) By deleting the second sentence of Chapter II, Section 1 in its entirety and substituting therefor the following:

"Only registered Active, Student and Life Members may vote on pending questions."

(4) By inserting a new sentence in Chapter III, Section 3 between the third and fourth sentences thereof as follows:

"The component society for Student members shall be entitled to send one delegate for each twenty-five Student members (or major fraction thereof) in good standing as of the close of the preceding calendar year."

(5) By adding a new sentence at the end of Chapter IX, Section 10 as follows:

"The component society for Student members shall be entitled to elect one delegate and one alternate delegate for each twenty-five student members (or major fraction thereof) in good standing as of the close of the preceding calendar year."

(6) By adding a new Section 12 to Article IX providing as follows:

"Nothing in Sections 1, 2 and 3 of Chapter IX shall be construed as preventing the Society from chartering a component society for students in good standing at the School of Medicine at the University of Iowa."

Members of the Committee and legal counsel will be present at the Reference Committee to answer any questions with regard to the proposed recommendations.

Respectfully submitted,
O. D. WOLFE, M.D., *Chairman*
L. R. FULLER, M.D.
D. A. HOWELL, M.D.
K. J. JUDIESCH, M.D.
E. G. KETTELKAMP, M.D.

COMMITTEE ON LEGISLATION

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

Following past custom the report will be divided into two sections dealing with federal legislation and state legislation.

FEDERAL LEGISLATION

A larger than normal complement of health related bills have been introduced this year on such items as drug abuse, pollution, inclusion of chiropractors under Medicare, and the cost of health care. The House Ways and Means Committee has been holding hearings on proposed changes to Medicare and Medicaid. Of the proposals considered, one is an administration proposal which would add a new Part C to Medicare to permit and encourage the delivery of all Medicare benefits through organizations somewhat similar to closed panel prepaid medical groups. The AMA feels that rather than adding this new Part C, the government should consider pilot projects to develop cost and other information before considering such a broad scope program for all Medicare recipients.

With the advent of Medicare and Medicaid, many individuals and groups stated that this was only the beginning in a great debate as to the financing of health care costs for the entire nation. This past year has seen the introduction of numerous bills advocating various means of providing compulsory national health insurance coverage. Included are bills introduced by the AFL-CIO, Walter Reuther's "Committee of 100," and the AMA with its "Medicredit" program. Few people expect any of these programs to receive detailed attention this year, but they may serve as the framework for a lengthy debate on the cost and delivery of health care in the future.

Representatives of the Committee on Legislation, IMS officers and staff traveled to Washington, D. C. on April 8 and 9 to meet with the Iowa Congressional Delegation. This year's meeting was extremely well attended and provided for a very stimulating and healthy exchange. This trip has become an annual function of the IMS and provides for better liaison with the Iowa Congressmen and Senators.

STATE LEGISLATION

The greater portion of this report will deal with state legislation. The year 1970 marked the completion of the second session of the 63rd General Assembly and the first full General Assembly of the newly-enacted annual sessions. This has been an extremely busy and rewarding year for the Committee on Legislation.

Every item of legislation introduced into the General Assembly is screened by legal counsel and in excess of 110 bills, although they are not necessarily a part of the IMS legislative program, still require the attention of the Committee on Legislation.

First, we will review four priority items; and at the end of the report you will find a complete listing of bills that concerned the IMS. Obviously the magnitude of health-related legislation requires the Society to establish a priority system for dealing with specific bills and with each session the question of priority becomes more crucial and difficult to answer.

The Committee feels this has been a successful session for the IMS. We were fortunate in this General Assembly since almost all legislation supported by the Society was enacted, and those measures opposed by the Society were defeated.

Professional Corporations (SF 554). This bill was considered the top priority item on the IMS legislative agenda. The bill was passed early in the session and will become effective July 1, 1970. It permits licensed practitioners to practice certain professions through a professional corporation. All incorporators, shareholders, directors, and significant officers must be licensed in Iowa or admitted to practice the profession which the corporation is to practice.

This bill does not affect a professional person's liability to clients, his duties as to privileged communications, nor the ethical standards of any profession.

Persons practicing through a professional corporation remain subject to state laws and state regulatory boards.

The Society, through a special News Bulletin, has given physicians certain guidelines to follow in determining their interest in a Professional Corporation.

Chiropractic-Proposed Change in the Chiropractic Practice Act (SF 91). During the 1969 session, this bill was re-referred to the Senate Judiciary Committee by just a one-vote margin. SF 91 remained in the Judiciary Committee throughout the 1970 session, despite repeated efforts by chiropractors to bring it to the floor of the Senate. The legislative contact men were instrumental, through their personal contacts with legislators, in keeping the bill in committee.

The chiropractors have spent a great amount of time and money in the support of this bill and it can be expected there will be a continued push to expand their practice act in future sessions of the legislature.

Another major chiropractic bill was defeated during the 1970 session (HF 205). This bill would have made it mandatory that all health insurance written or renewed after July 1, 1970 cover chiropractic services. This bill passed the House in 1969 and reached the Senate Calendar in 1970. However, again due to the efforts of the legislative contact men and other phy-

sicians the bill was never considered by the full Senate.

State Crime Laboratory (SF 585). This bill establishes under the control, supervision and direction of the Commissioner of Public Safety a State Criminalistics Laboratory. The Commissioner appoints the Director of the lab and determines the placement of the lab. Also, the bill creates the position of State Medical Examiner, who must be a physician with special knowledge in Forensic Pathology. The State Medical Examiner is an appointee of the Governor for a 6-year term. The duties of the State Medical Examiner are: 1) Provide assistance, training and consultation to county medical examiners and law enforcement officials; 2) Keep complete records of all relevant information concerning deaths or crimes requiring investigation; 3) Establish rules and regulations as to manner and technique of investigation and reports, as well as other necessary actions to carry out a medical examination. The bill also changes the provision for payment of $15 plus actual expense for a written report by the county medical examiner to a fee as negotiated with the County Board of Supervisors.

Opticians Registration (SF 288). This bill provides for registration and certification of dispensing opticians and would allow, by law, that a certified dispensing optician may fit contact lenses both on prescription from a physician or optometrist. This proposal never received approval by committee, the main reason being that the legislators felt it was special interest legislation and did not wish to give it consideration this session.

The 64th General Assembly no doubt will prove to be an extremely interesting session since the size of the legislature will be reduced from the present 61 senators and 124 representatives to 50 senators and 100 House members. There will be new leaders and many new faces. A concentrated effort by physicians to participate in the upcoming election will be required if we wish to continue to have a successful legislative program.

It is obvious that the Society's involvement in the legislative area has, of necessity, greatly increased in the past few sessions of the General Assembly. Legislative activity has become a year-round function of the Committee, and therefore of the Society's legal counsel and staff. The physicians of Iowa should realize the importance of the Medical Society's activity in health legislation, and lend support by taking an interest at the local level not only in specific legislation but also in efforts prior to elections to assure that those elected to office have some appreciation of medicine's position on legislation. This can be accomplished only by participation in governmental affairs both before and after elections.

County medical societies, as well as individual doctors, have a responsibility to become acquainted with their legislators. An excellent method followed by many county societies is to periodically invite all legislators in the area to attend county medical society meetings. It is not necessary that they take part in a formal program on each occasion, but they can be invited merely to attend as guests. The Committee on Legislation would suggest that, as a minimum, this should be done at least twice a year—once before each session and once following each session of the General Assembly.

In conclusion, the Committee would like once again to thank the legislative contact men, without whose help the Society's legislative program would not achieve the success it does. The LCM program will need to be refined, and efforts are under way to see that this occurs.

Respectfully submitted,
J. H. KELLEY, M.D., *Chairman*
J. L. BEATTIE, M.D.
C. L. BEYE, M.D.
G. R. CLARK, M.D.
W. R. HORNADAY, JR., M.D.
C. N. HYATT, M.D.
J. E. KELSEY, M.D.
ERLING LARSON, JR., M.D.
R. D. LIECHTY, M.D.
W. C. MCCORMACK, M.D.
W. J. MORRISSEY, M.D.
W. J. ROBB, M.D.
G. I. TICE, M.D.
O. D. WOLFE, M.D.

Dr. Kelley summarized the preceding report and introduced O. D. Wolfe, M.D., Chairman of the Iowa Medical Political Action Committee. Dr. Wolfe offered brief remarks and introduced a new IMPAC audio-visual presentation on political participation by the medical profession. He advised that the presentation is available for use by county medical societies.

SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

At a meeting on March 4, 1970, this Subcommittee gave principal attention to two subjects.

1. *Rubella Eradication Program.* As is reported in the HANDBOOK FOR THE HOUSE OF DELEGATES, this program has occupied the interest of the Subcommittee to a considerable degree this year. At the March 4 meeting the Subcommittee was advised that 236,779 Iowa children have received the rubella vaccine in the statewide program. At that time 21 county-wide rubella programs had been completed and 32 more were on the schedule. It was anticipated the 45 per cent of the population at risk would have been covered by the first week in March. These figures will have been far surpassed by the time the House of Delegates considers this report; they are provided simply to dramatize the significant progress to that point. The Subcommittee has been informed that medical society approval to conduct rubella programs has been received by the State Department of Health from 97 of the 99 counties.

The Subcommittee believes this statewide effort is worthy of commendation, and it would encourage the 1970 House of Delegates to recognize the county medical societies and the Department of Health for this cooperative endeavor which is now achieving broad success.

2. *Therapeutic Abortion.* Referral by the IMS Executive Council of a recommendation from the Subcommittee on Psychiatric Care prompted this further consideration of therapeutic abortion on March 4. Reference in this extensive deliberation was made to:

A. *The present position of the Society.* It was recalled that in 1968 the IMS House of Delegates sus-

Doctor, after all we've been through together...

abscess
acne
amebiasis
anthrax
bacillary dysentery
bartonellosis
bronchitis
bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
psittacosis
pyelonephritis
Rocky Mountain spotted fever
scarlet fever
septicemias
sinusitis
soft tissue infection
tonsillitis
tularemia
typhus fever
urethritis

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tained the recommendations of the Subcommittee on Maternal and Child Health and authorized the Society to support a liberalization of the abortion law in Iowa, providing certain guidelines were included. The Committee recalled further that in 1969 the House of Delegates (by a vote of 86 to 23) reaffirmed the 1968 action. In its 1968 action the IMS House of Delegates endorsed the AMA Statement on Therapeutic Abortion and added the following stipulations regarding any state legislation:

1. The bill should repeal or modify existing provisions of Iowa law where this is indicated and should contain appropriate provisions as to the crimes of abortion, attempted abortion and distribution of abortifacients.

2. The bill would legalize the termination of a pregnancy only when:

a. The procedure is requested by the patient (with suitable provisions for obtaining such voluntary request in the case of patients who are under legal disability); and

b. There is documented medical evidence that continuance of the pregnancy may threaten the mental or physical health or life of the mother; or

c. There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency; or

d. There is documented medical evidence that continuance of a pregnancy, resulting from legally established or reported statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient; and

e. Two other physicians chosen because of their recognized professional competence (both of whom should be psychiatrists in cases involving mental health) have examined the patient and concurred in writing; and

f. The procedure is performed by a licensed physician and surgeon in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

3. The bill should expressly provide that the refusal of any hospital, physician, or person employed by a hospital, to participate in the medical procedures which result in the termination of a pregnancy shall not form the basis for any disciplinary action or recrimination against such hospital, physician, or person.

B. *The recent recommendation of the IMS Subcommittee on Psychiatric Care.* This Subcommittee submitted to the IMS Executive Council in January a recommendation calling for a substantial change in the Society's position on abortion. The recommendation was received by the Council and referred to the Subcommittee on Maternal and Child Health for study. The recommendation urged that any decision regarding an abortion be left strictly up to the pregnant woman (and her spouse) and her physician.

C. *The legislation proposed by State Senator Charlene Conklin.* This bill (S.F. 1052) substitutes the words "an illegal termination of pregnancy" for "a criminal abortion" in the existing law. It also declares that any person other than a qualified physician who attempts to terminate a pregnancy is guilty of practicing medicine and is subject to a heavy fine and imprisonment. The bill is in committee as this report is prepared and prospects are that it will remain there during the balance of the 1970 session. In line with this, reference was made to the effective activity of several women's groups in seeking consideration of the bill during this session of the General Assembly.

D. *The resolutions submitted by the medical societies in Clinton and Scott counties.* It was noted that these resolutions request the Society either (1) to support the concept espoused in the Conklin proposal, or (2) to work for the abolition of all state statutes pertaining to abortion.

In the Subcommittee's extended deliberation, reference was made to various factors and developments which bear on the subject of therapeutic abortion. These included:

1. The reported failure of the liberalized legislation enacted in Colorado three years ago. It is apparently not achieving the desired objective in that only about 15 per cent of the population (those in the upper socio-economic segment) appear to be requesting termination of pregnancy under these new statutes.

2. The legislation recently passed in Hawaii which has implications similar to the Conklin proposal and which emphasizes that any abortion should be a patient (with spouse) -physician decision.

3. The fairly recent reform of the abortion laws in England which are seeking to get at the legal, ethical and practical problems there.

4. The action taken by the AMA House of Delegates at the 1969 Clinical Meeting in refusing to modify or change the therapeutic abortion position adopted in 1967, a position which has received the endorsement of the Iowa Medical Society.

5. The several court actions taken or pending which have ruled unconstitutional long-standing abortion laws in several states, e.g., California, Washington, D. C. It understood the Iowa Civil Liberties Union has given consideration to testing the Iowa law in court.

The members of the Subcommittee believe (1) the approach represented by the Conklin legislative proposal is inevitable, and (2) that the Society would do well to acknowledge and support this line of thinking at this time. It is, in the judgment of the Subcommittee, a pragmatic response to an emotional issue; so long as no one is required to participate against his or her will, the Subcommittee is of the opinion that the approach deserves favorable consideration.

The Subcommittee wishes to record itself as unanimously in support of the recommendation of the Subcommittee on Psychiatric Care, which runs parallel to the resolutions of Scott and Clinton counties and to the content of the Conklin legislative proposal. It was agreed this position should be transmitted to the 1970 IMS House of Delegates in the form of a supplemental report. The Subcommittee further agreed that serious thought should be given by the Society to making sure that in any legislation there be some means of assuring that any abortion performed in Iowa be so performed in a licensed hospital, which operates under staff rules and regulations.

Respectfully submitted,
W. J. BALZER, M.D., *Chairman*
MADELENE M. HEALY, M.D.
CHARLOTTE FISK, M.D.
A. L. JENSEN, M.D.
J. C. MACQUEEN, M.D.
D. O. NEWLAND, M.D.
C. P. PHILLIPS, M.D.
C. W. SEIBERT, M.D.
J. M. WALL, M.D.
J. J. WEYER, M.D.

SUBCOMMITTEE ON PUBLIC ASSISTANCE

Report of the IMS representative (L. J. O'Brien, M.D.) to the Medical Assistance Advisory Council to the Department of Social Services

(Referred to the Reference Committee on Insurance and Medical Services.)

This is not a report of the Subcommittee on Public Assistance, but is a personal report by me as the Society's representative to the Medical Assistance Advisory Council. The last meeting of the Council was held April 7, 1970 and there has been no opportunity to have a meeting of the Subcommittee on Public Assistance.

Within the last few days we have received a report from Elmer Smith, M.D., on a matter under discussion in the Department of Social Services concerning physical examinations. I felt this matter should also be brought to your attention.

"Recently the Carrier has brought to our attention numerous claims for routine physical examinations in which total charges appear to be excessive, resulting in most instances from charges for a large number of diagnostic procedures and laboratory studies. In some instances total charges for the examination were in excess of $150.00. We repeat that this was for a *routine* physical examination in which the patient presented no complaints which would justify the need for such a range of diagnostic procedures and in which the findings of the examination were essentially negative.

"We are giving consideration to a revision in policy in which a maximum allowance of $25.00 would be established for a routine physical examination. This would include the routine history and physical with laboratory examination (urinalysis and blood count). Payment would be approved for additional diagnostic procedures, e.g., chest x-ray, EKG, etc., only if the condition of the patient indicated the need for such procedures. In this event the physician would be required to submit a report attached to his claim explaining the need for the additional diagnostic procedures or studies."

A meeting of the Medical Assistance Advisory Council was held April 7, 1970. At this meeting presentations were made by State Representative Joan Lipsky, Chairman of the Legislative Medicaid Study Committee and by Elmer Smith, M.D., Medical Director, State Department of Social Services.

In reporting on the *current status of Title XIX funds*, Dr. Smith cited factors which have contributed to the marked increase in the cost of the Medicaid program. These include 1) the original underestimation of cost because of inadequate studies, possibly to get more acceptance of the program by projecting a low cost; 2) the hasty and improper planning apparently done by an insufficient number of staff members; and 3) the national bug-a-boo, inflation, which has had its impact on Medicaid, as reflected by hospital costs and by the increase in salaries which must be paid to hospital personnel because of the minimum wage law and other factors. The numerous and prolific rules and regulations sent down by the Department of Health, Education and Welfare have likewise had a great impact on Medicaid. Lastly, the program was imposed on medical and paramedical personnel insufficient in number to deliver the quality and quantity of care envisioned in the program.

Iowa has spent approximately $2,036,000.00 per month on Medicaid for the period from July 1, 1969 to March 31, 1970. This is a total of $18,329,590.00.

The various *HEW regulations* continue to pose problems for the Iowa Medical Society and the Department of Social Services. On February 13, 1970, HEW indicated vendors must sign an agreement to substantiate the cost of any services provided. This provision is covered in the new billing forms being provided by DSS for Title XIX patients.

HEW regulation 40-15 requires that payment to all vendors by the Department be reported to the Internal Revenue Service. A random sampling of recipients is reportedly to be undertaken to assure that services were provided as reported. This latter function is to be implemented by the carrier for Title XIX.

Another regulation, 40-16, makes it mandatory for a state Medicaid program to 1) license administrators of nursing homes; 2) to set up standards for this licensure; and 3) to establish a school where nursing home administrators may be trained. The operational cost of this educational program is to be assumed 75 per cent by federal and 25 per cent by state, and must be carried out in an approved sponsoring college. The source of the 25 per cent funds to be provided by the state of Iowa has not been determined.

The Utilization Review program is becoming more effective in determining recipient abuses. Recipient abuse has come to light in the Peer Review process and also in the investigations of the Legislative Study Committee. The problem common in both investigations was that certain recipients go apparently simultaneously to several doctors. It has been suggested that this be corrected by having the County Welfare worker confer with the individual recipient and designate a primary physician or a primary pharmacy. Under consideration is the discontinuance of payment for routine physical examinations (this matter is discussed at the outset of this report) because of extremely high costs. The Department has suggested the small amount of medical benefit is not commensurate with the cost.

The *Quality Assurance program* has become increasingly effective in dealing with both under-utilization and with over-utilization. For the month of February the parameters which were used in the QAP saved approximately $29,000. Peer Review is being discussed in depth in other reports to the House; suffice it to say that the DSS and the Legislative Medicaid Study Committee are well satisfied with Peer Review. It is felt that Peer Review is the appropriate mechanism for doctors to use to supervise their own programs. In the report of the Legislative Medicaid Committee, Representative Lipsky stated "that a desirable policy would be continued reliance upon the existing Peer Review procedure, but with a systematic attempt to better interpret to the general public, particularly the legislature, the role of the Peer Review Committees and, at the same time, to interpret to the Peer Review Committees the concerns of the public regarding Medicaid. The Medicaid Study Committee felt that the several professional groups should involve designated legislators as *observers,* to the extent feasible, participants in the Peer Review process." The Iowa Medical Society has expressed preference for legislative involvement at the state rather than the regional level.

The report of the Medicaid Legislative Study Committee with its suggested revisions in the Medical As-

sistance Act were discussed at the Advisory Council meeting by Representative Lipsky. The Legislative Committee recommended and statutory authority was subsequently given by the 1970 General Assembly to effect the following changes in Iowa's Medicaid program:

1. Medical assistance is defined as comprising the five basic services authorized under Title XIX, while "additional medical assistance" means all of the services under federal provisions of Title XIX. The committee's basic desire here was to assure that the scope of the Iowa Medicaid program could be made by the General Assembly through the appropriation process. In evaluating this action, it should be remembered that a substantial part of the expenditures for "additional medical assistance" is taken up by prescription drugs and by payment to dentists. Consideration must be given to the adverse reaction which could come from the discontinuance of "additional medical assistance" in Iowa Title XIX. Interestingly, total institutional care in Iowa takes 38 per cent of the Medicaid dollar, contrasted nationally with 68 per cent of the Medicaid dollar going for institutional services. You see the much greater emphasis in Iowa on care outside of the hospital.

2. Eligibility determinations were spelled out more clearly so that the adverse federal court ruling (the Dimery case) could be corrected. New amendments:

a. Require that Medicaid be provided to those persons who must be covered if the state is to qualify for federal participation and

b. Empower the Commissioner of Social Services to extend Medicaid coverage to certain specified groups in accordance with specific guidelines when available funds allow the Commissioner to do so in accordance with an order of priority.

3. The amended Medicaid law also requires the Commissioner of Social Services to *review at least every six months the Iowa Medicaid program and to report to the Executive Council.* This is a directive to the Commissioner to operate a broad program within the overall limits of the Medical Assistance Act, keeping the services in relation to the money appropriated by the General Assembly. It is understood also that the same report will be made by the Commissioner to the Medical Assistance Advisory Council at the semi-annual meeting.

The attention of the House is directed to the importance of the IMS maintaining ongoing discussion with legislators at the state and national level. Emphasis should also be directed at your individual interest in the choice of legislators at both the state and national level; this is important since so much having to do with the delivery of medical care is being determined by state legislators in the General Assembly and by the legislators nationally; their impact even laps over into the rules and regulations which are set down by HEW. Policy making is slipping away from us and away from the local level under the influence of HEW on both Titles XIX and XVIII. it behooves us as individuals and as a group to make our presence known through political affiliation and political "pressures," if you will, on all legislators.

The Legislative Study Committee expended considerable energy evaluating the cost of the Medicaid program. It accepted the usual, customary and reasonable concept in the payment of physicians' fees. It has been emphasized repeatedly that physicians are to submit

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9132 Dorcas Street, Omaha, Nebraska Telephone: 402-393-5797
Mailing Address: Elmwood Station, Box 6076, Omaha, Nebraska 68106

their usual fees for any services provided. As you know, HEW arbitrarily cut back Medicaid payments and is requiring use of 1968 fee data as base for determining payment. Strong protestations were made by the Iowa Medical Society to this arbitrary cutback. In Iowa, however, we were more fortunate than in some states where they were cut back to a three-dollar or four-dollar unit fee. Iowa physicians are receiving Medicaid and Medicare payments on the basis of the 83 percentile, based on 1968 fee data. The carrier has been allowed to maintain that level of payments in the Title XIX program.

Recently, some physicians have experienced a reduction in the fees paid to them for services rendered under the Title XIX program. When payments were first instituted an empirical figure (1968) was employed to weigh the usual fees submitted by the physician against that of his colleagues in the same area. As statistical information was accumulated by the carrier, it became possible to derive a valid computerized figure replacing the empirical figure. In some instances the computer projection was lower than the empirical figure. As a result, some physicians are having their fees lowered. The fee profile was originally more accurate for surgical fees than for medical fees; the greatest number of fee reductions has occurred in the latter area. For the 8-month period, July 1, 1969 to March 1, 1970, Iowa physicians have received approximately $3,298,000 on the basis of the above methods of payment.

One of the more ominous signs with regard to Medicare is that on a national level the application of the same methodology is being seriously considered by legislators as a method to cut costs. Discussion of this is not an integral part of Title XIX but it is submitted as one of the dark clouds on the horizon.

After diligent questioning and search, the *cost of the Medical Assistance Program* for the fiscal year ending June 30, 1969 has been found. The total state administrative expense is $1,240,920.97 while the fiscal agent's fee is $1,149,070.03, making a total of $2,389,991. These expenses are not in the amounts which are appropriated for the biennium for the Medical Assistance Program. However, the expenditures for administration of the program in Iowa represents about 8 per cent of the total cost of the program.

In keeping with current trends, the *public is to have a greater representation*, meaning that the Medical Assistance Advisory Council is to be enlarged from one to four representatives; these are to be appointed by the governor.

There has been considerable discussion of the use of a *private insurance company to provide (underwrite) Medicaid benefits* to some or all eligible recipients through a group insurance policy. As you have been informed in previous reports, discussions of this nature have been going on for over a year and some insurance companies have evidenced interest in providing this type of group insurance. As this report is prepared, it is understood that three insurance groups have asked for the specifications to act as a carrier for the Medicaid program. The bids for the carrier are to be opened on April 20 and more will be known of the fiscal intermediary status at that time.

This report on the Medical Assistance Advisory Council is lengthy; this is acknowledged, but it is felt this program is of sufficient importance to justify careful consideration by the House of Delegates.

Respectfully submitted,
L. J. O'BRIEN, M.D., *Chairman*
A. J. HAVLIK, M.D.
G. P. HAYES, M.D.
L. J. KIRKHAM, M.D.
P. J. LEEHEY, M.D.
R. J. REED, M.D.
J. E. REEDER, JR., M.D.
ISAAC STERNHILL, M.D.
K. H. STRONG, M.D.

SUBCOMMITTEE ON SAFE TRANSPORTATION

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

The IMS Subcommittee on Safe Transportation has obtained information from officials of the Iowa State Highway Patrol regarding the status of the Emergency First Aid Station Program that is currently being developed in Iowa, and the Committee felt that the House of Delegates should be apprised of this program, even though reports have appeared in the public press.

The project is being implemented by the American National Red Cross, with cooperation from the Iowa State Highway Patrol. In essence, the objectives of the program are to (1) establish first aid stations on Iowa's Interstate Highway System, and other primary roads, where it has been determined that there is a high accident-frequency rate; and (2) to place first-aid trained personnel at these locations.

Ultimately, it is anticipated that there will be 48 first aid stations located on Iowa's Interstate System. However, as a result of a 9-month accident-frequency study the following locations have been selected as initial top priority sites:

County	*Junction*
Pottawattamie	80-29/80-59/80-71
Hamilton	35-20
Decatur	35-2
Jasper	80-14
Poweshiek	80-146
Johnson	80-6/80-1
Scott	80-130/8

It should be noted that it is anticipated that facilities of restaurants, motels or service stations will be utilized at the designated locations for first-aid purposes.

Members of the Iowa State Highway Patrol will participate in a meeting in the near future, at which time guidelines for the selection of potential first-aid trainees will be outlined. The patrolmen will then be charged with the responsibility of making initial personal contacts with individuals in the first-aid station area who might be interested in and qualify for participation in the program.

The American Red Cross will provide Standard and Advanced First Aid Training, as well as the necessary first-aid supplies. It will also erect Emergency First Aid signs at the sites where the facilities are to be located in order to alert the public that such a station is in operation.

In addition to the sites located on the Interstate System, the Red Cross plans as a second priority to train first-aid teams that will function in areas of rural Iowa that are some distance from professional medical help. As explained by the Red Cross, such

persons could administer immediate and temporary first-aid, as well as initiate necessary steps in providing transportation for the injured to the nearest medical assistance.

In response to a communication from the Director of Public Safety for the American Red Cross, it was suggested that information regarding the distribution of physicians and medical facilities in the state be obtained from Doctor John MacQueen, Associate Dean, University of Iowa College of Medicine, who has comprehensive statistical data on this subject. In addition, the Red Cross Director was encouraged to consult with representatives of appropriate county medical societies as this phase of the Emergency First Aid Station Program is developed.

The Committee has been advised that this project is being conducted on a voluntary basis, with support coming from the American Red Cross and the local areas involved, perhaps through local civic and service organizations, etc.

The Safe Transportation Subcommittee will continue to maintain liaison with the Department of Public Safety, the Red Cross and any other organizations as this and similar type programs are developed.

Respectfully submitted,
A. H. DOWNING, M.D., *Chairman*
J. T. BAKODY, M.D.
E. H. BARG, M.D.
W. E. CATALONA, M.D.
C. S. CRUSINBERRY, M.D.
J. F. KELLY, M.D.
C. W. MAPLETHORPE, JR., M.D.
R. A. WILCOX, M.D.

Supplemental Reports of Special Committees

The Speaker next called for the presentation of supplemental reports from special committees.

COMMITTEE ON ONCOLOGY

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

The Committee on Oncology has had under study a recommendation that the Iowa Medical Society spearhead the creation of a statewide "Cancer Control Commission" to serve as a mechanism to eliminate duplication of effort and to coordinate the activities of the various professional and voluntary organizations in Iowa concerned with improving cancer care. The proposal was submitted to the IMS by Joseph A. Buckwalter, M.D., Director of the Iowa Cancer Information Service.

Although there has not been opportunity for the committee to develop specific recommendations in this regard, some members have responded favorably, while others have expressed the opinion that a cancer control commission would not serve a useful purpose in this state.

The Committee on Oncology respectfully seeks the guidance of the House of Delegates with respect to IMS involvement in spearheading the creation of a statewide "Cancer Control Commission."

It might interest the House of Delegates to know that immediately prior to the Annual Meeting, a communication was received from the Medical Society of the State of New York inviting a representative of the IMS to attend an unofficial meeting in Chicago during the AMA Annual Session to discuss the desirability and feasibility of stimulating the AMA to appoint an official Committee on Cancer within its organizational structure. Representatives of other state medical societies are also being invited to attend the conference, which will be primarily informational, and it is anticipated that a member of the Iowa delegation will be present.

Respectfully submitted,
G. R. CLARK, M.D., *Chairman*
DAVID BARIDON, JR., M.D.
J. A. BUCKWALTER, M.D.
S. A. COHEN, M.D.
K. R. CROSS, M.D.
J. R. DORAN, M.D.
D. O. HOLMAN, M.D.
H. W. MORGAN, M.D.
F. W. STAMLER, M.D.
R. E. WELAND, M.D.

STATE CLAIMS REVIEW COMMITTEE

(Referred to the Reference Committee on Insurance and Medical Service.)

There are three items which the State Claims Review Committee wishes to submit to the House of Delegates. These involve (1) a brief summary of those cases considered by the State Claims Review Committee during 1969-1970; (2) a report on payment for surgery and surgical assistants under Medicare; and (3) establishment of "standards of medical care."

Summary of Cases Reviewed

The number of cases sent to the State Claims Review Committee during the past year has decreased. Much of this is due to increased understanding of claims review by both third parties and physicians, plus the more active work of district peer review committees. The vast majority of cases reached a satisfactory adjudication at the district level, which did not call for review by the State Claims Review Committee.

During the past year the State Claims Review Committee has considered eight cases. Most have dealt with disagreement between a physician and the Carrier relating to the determination of a "prevailing charge." We find there is still misunderstanding among physicians on the rigidity of federal regulations regarding the determination of a reasonable charge. The application of mandatory federal guidelines normally leaves the State Claims Review Committee with little latitude in approving a charge submitted by a physician when it exceeds the "prevailing charge" in that area for services of a similar nature.

The second problem area deals with long-term medical care for patients in extended care facilities or skilled nursing homes. There still exists widespread disagreement on the interpretation of federal guidelines as they pertain to payment for "custodial care vs medical care."

As more information is made available to physicians through the Medical Society and the office of the Carrier, it is assumed these two items will reach a level of clearer understanding and fewer cases will be referred to district peer review committees and/or the State Claims Review Committee for adjudication.

Listed below are the cases considered by the Committee during the year:

Case 97-1	Physician's Charge $290.00 Committee Approved $200.00
Case 7-1	Physician's Charge $400.00 Committee Approved $350.00
Case 97-2	Physician's Charge $400.00 and $50.00 Committee Approved $360.00 and $40.00
Case 77-14	Physician's Charge $300.00 Committee Approved $250.00
Case 77-11	Physician's Charge $1,050.00 Committee Approved $1,000.00
Case 77-22	Physician's Charge 600.00 Committee Approved $551.00
Case 77-23	Physician's Charge $300.00 Committee Approved $275.00
Case 69-1	Physician's Charge $530.00 Committee Approved $265.00

Report on Payment for Surgery and Surgical Assistants Under Medicare

The 1969 House of Delegates in considering the State Claims Review Committee report endorsed the appointment of a special Subcommittee to meet with the Medicare Carrier and representatives of HEW to evaluate the administrative problems involved in payment of surgical and surgical assistants' fees. The House was aware of the problems inherent in the payment of surgical and surgical assistants' fees and recognized that customs vary in different parts of the state which variation further complicates the handling of these claims.

Since the beginning of Medicare the Iowa Medical Society and the Medicare Carrier have each received many inquiries from physicians both in family practice and surgical specialities as to exactly how payment for surgery and surgical assistants is determined under Medicare. The Carrier has always been guided by the official policy of the Iowa Medical Society.

During its deliberations the Subcommittee conducted a most exhaustive study of the historical background of Medical Society policy on this subject. This included action of this House, the Executive Council, the Judicial Council and the AMA House of Delegates and Judicial Council.

Basic to the Committee thinking has been agreement that treatment for a surgical illness includes the following five components:

(1) The patient workup.
(2) Normal pre-operative care.
(3) Surgery.
(4) Surgical Assistant.
(5) Normal post-operative care.

The difficult administrative problem of the Carrier is to determine which of these services were rendered by a physician who has submitted a claim for payment. Historically, in many parts of Iowa claims for surgery have been submitted on a "package charge" basis, which has included the charge for all five components, even though more than one physician may have been involved in the care of the patient. Because of this factor the surgical charge information used by the Carrier has been maintained on this "package charge" basis. Charge profiles have not been developed on each of the five separate components since most claims received list one charge representing all five components. Even when a physician has not rendered all five services, many physicians have been reluctant to list a charge less than their normal charge for all five components because of the effect this might have on their computer profile. All of these factors have too many times resulted in an incorrect or inadequate payment being rendered to one of the physicians involved in the treatment of a surgical illness.

Based on its study the Committee offers the following observations:

1. The Medicare Claims Form (SSA-1490) includes the following certification statement:

"(A physician's signature certifies that physician services were personally rendered by him or under his personal direction.)"

Rendering of a statement "for professional services" to a patient even though not assigned and not on a Medicare Claim Form (SSA-1490) is interpreted by HEW as carrying the same degree of certification by the physician as signing the Medicare Claim Form.

The Federal False Claims Act provides for civil recovery of double damages for claims (this includes Medicare claims) filed falsely. In addition, criminal fraud provisions apply when intent to defraud is established.

To conform to the above HEW takes the position that Medicare billings must clearly identify the exact scope of services for which billing is being made. *If the claim includes a billing for services of any other physician, specific identification of that physician and the charge for his service must be included on the claim form.*

2. Charges submitted for surgery usually include all five components and the Carrier's charge information is maintained on this basis. Where a surgeon performs an operation but does not render all five components the Carrier should be able to determine a reasonable charge for only those components of care actually rendered. If another physician has rendered one or more of the components, the Carrier should be in a position to determine the reasonable charge for only those components. *However, the total reasonable charge for the services of both physicians cannot exceed the reasonable charge for the five components had one physician billed for the full range of services.*

3. The determination of a reasonable charge under Medicare needs refined. One of the basic principles of Medicare is for each physician to determine his own charge for a medical and surgical service. For the Carrier to accurately determine a reasonable charge, claims submitted must describe and define the exact services rendered in order to permit grouping of only identical services for purposes of determining a reasonable charge.

4. The Carrier should establish customary charge profiles for the components of a surgical service in order for it to build appropriate prevailing charges for the payment of claims. To accomplish this goal, claims must clearly identify the exact services personally rendered by the physician submitting the claim.

Two points seem to evolve from the Committee's study:

1. Medicare is based on the physician placing a value on his service and the program paying for that service within the charge guidelines established through federal law and regulations. In order to fulfill this commitment the Carrier must be able to identify exactly what surgical service components the physician rendered:

(1) Was it all five components?
(2) Was it assistant surgery only?
(3) Was it assisting plus workup and pre- and post-operative care?

(4) Was it only the surgical operation?

Each possible combination must be treated as a discrete service and valued as such in the Carrier's record if the physician and patient are both to be treated with equity.

2. The total financial obligation of the program cannot be increased solely because of any revision or change that might occur in the Medicare billing and/or payment process.

The Committee recommends that in the future all claims submitted by physicians should indicate which of the five components of a surgical illness are represented by the charge listed on the claim form. Such itemization will result in a more equitable administration of third party programs, particularly Blue Shield, Medicare and Medicaid.

To implement this recommendation the Committee feels that an educational program should be undertaken by the Iowa Medical Society and Blue Shield. Such an educational program should involve all physicians but perhaps with special emphasis on physicians practicing family medicine or a surgical specialty.

The Committee believes that nothing in this recommendation will require a change in the long established policy of the Iowa Medical Society with regard to payment for surgery and surgical assistants. *However, if the recommended program is to succeed, great attention will need to be devoted to the completion of claims by physicians.*

The Committee recognizes that close liaison will be required between the Iowa Medical Society and the Carrier to assure physicians that the Carrier has methods to properly identify and code claims for surgery. Only with this assurance could the program be favorably received.

Establishment of Standards of Medical Care

As third parties have become more deeply involved in financing of medical care there has been increased interest on the part of these third parties in establishing guidelines or standards of medical care to be applied in processing or paying claims.

Many state and county medical societies have undertaken comprehensive programs to evaluate what is an acceptable or a standard broad community profile of health care services and delivery. Many county medical societies have established foundations for medical care, which play an active role in the establishment of "standards of medical care." This has served to leave to medical determination those essential elements of judging the quality and quantity of medical care.

The State Claims Review Committee has, as an administrative mechanism, adopted certain guidelines which it uses in adjudicating cases. Many of these guidelines are well understood and generally accepted by the profession as a whole. Other guidelines or standards are not widely recognized and the need for more definitive guidelines becomes increasingly apparent. As a most needed aid to District Peer Review Committees of the State Claims Review Committee the establishment of "standards of medical care" generally accepted and understood by physicians would be of tremendous value in carrying out the peer review task which the Society has strongly endorsed.

The State Claims Review Committee recommends that the Society assign to an appropriate committee the responsibility for formulating "standards of medical care" which can be made available to the physicians of Iowa and responsible peer review committees in an increasing effort by the Society to discharge its responsibility for maintaining high quality medical care at a reasonable cost available to the citizens of Iowa.

Representatives of the State Claims Review Committee will be in attendance at the Reference Committee hearing to elaborate in more detail on the meaning of "standards of medical care" and to answer other questions relating to the recommendations of the Committee.

Respectfully submitted,
R. S. GERARD, II, M.D., *Chairman*
D. C. ALFTINE, M.D.
A. REAS ANNEBERG, M.D.
W. A. CASTLES, M.D.
W. C. FRIDAY, M.D.
V. R. HEIMANN, M.D.
R. M. KAPLAN, M.D.
J. K. MACGREGOR, M.D.
G. A. PASCHAL, M.D.
V. L. SCHLASER, M.D.

COMMITTEE ON VOLUNTARY HEALTH AGENCIES

(Referred to the Reference Committee on Legislation and Miscellaneous Business.)

In its HANDBOOK report to the House of Delegates, the Committee on Voluntary Health Agencies introduced the idea of a program to provide an annual recognition by the Iowa Medical Society to those state voluntary health organizations desiring it. The program was reported as being under study by the Committee.

The particular recognition program which the Committee has reviewed is operated by the Indiana State Medical Association. Based on its evaluation of the Indiana program, the Committee has voted to recommend to the IMS House of Delegates that a similar type of recognition be accorded to the voluntary health agencies in Iowa. This supplemental report is to request the House of Delegates to approve the concept of this program and to authorize the Committee to proceed with its implementation.

The program would require interested agencies to complete and submit a detailed questionnaire to the Society. A careful evaluation will be made of the questionnaires by the Committee, and those agencies found to be operating soundly will be issued a certificate of recognition suitable for framing and posting. As mentioned in the preceding, the certification would presumably be repeated on an annual basis.

The intent of the program is reasonably clear. It would serve to increase the liaison between the Society and the various voluntary health agencies; and it would recognize the prudent operation of these organizations.

The 1970 IMS House of Delegates is requested to authorize the Committee to proceed with this program.

Respectfully submitted,
C. E. SCHROCK, M.D., *Chairman*
G. F. FIESELMANN, M.D.
K. K. HAZLET, M.D.
J. E. KELSEY, M.D.
E. A. MOTTO, M.D.
J. W. RATHE, M.D.

RESOLUTIONS

CLINTON COUNTY MEDICAL SOCIETY
NO. 1. ABORTION LEGISLATION

(Referred to Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, The Clinton County Medical Society recognizes the ever present and growing problems of birth control and overpopulation in the United States of America; and

WHEREAS, An ever increasing number of children are born each year with birth defects due to causes beyond medical control; and

WHEREAS, Many children born each year are unwanted by their natural parents, and many of them are cast into a society not able to cope with their social, medical or psychological needs; and

WHEREAS, The present abortion legislation is detrimental to the health of some pregnant women, and is cruel, inhuman, antiquated, and not in the best public interest; and

WHEREAS, Our society recognizes the freedom of choice of individuals to promote the public good and welfare; and

WHEREAS, It is in the public interest that the decision whether or not to abort, should be a medical and personal decision between patient and physician; be it therefore

Resolved, That the Clinton County Medical Society recognizes and confirms the ever increasing problems of the population explosion, the increasing number of needless deformed births each year, and the psychological-mental problems of some pregnant women; and be it further

Resolved, That it is not the function of society to legislate morals, but rather to strive to seek the highest and best public good for all its citizens, and that it is in the best public interest that each individual question of abortion is a medical-personal decision existing between patient and physician; be it further

Resolved, That the Clinton County Medical Society, in light of the above, go on record in favor of the abolition of all abortion legislation; be it further

Resolved, That a copy of the Resolution be sent to the Iowa Medical Society for presentment at the next regular meeting, that a copy be sent to all of the Clinton County Representatives and Senators, and further that a copy of this Resolution be given to all news media in Clinton County for publication; be it further

Resolved, That George Aurand, M.D., is appointed to perform all acts necessary to accomplish forwarding of the Resolution to the designated agencies and persons.

SCOTT COUNTY MEDICAL SOCIETY
NO. 2. ABORTION LEGISLATION

(Referred to Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, The Scott County Medical Society recognizes that questions of medical necessity for terminating pregnancy are best left to physicians; and

WHEREAS, The Society further recognizes that questions of what is moral and what is immoral are best left to the individual, his conscience and his religion; and

WHEREAS, This Society believes firmly in the right of the individual to act in complete freedom so long as he does not interfere with the freedom of others; therefore be it

Resolved, That this Society favors removing the medical and personal decisions covering termination of pregnancy from the control of the State, leaving only such safeguards as are necessary to protect the public; and be it further

Resolved, That to this end, the Society requests the support of the Scott County Senators and Representatives in securing the enactment into law of Iowa Senate File 1052; and be it further

Resolved, That the Iowa Medical Society be requested to lend its prestige, influence and assistance to the support of such legislation; and be it finally

Resolved, That public support of Senate File 1052 be sought by furnishing copies of this resolution to the news media of Scott County and to the DES MOINES REGISTER.

MARION COUNTY MEDICAL SOCIETY
NO. 3 VEXATIOUS LITIGATION (MALPRACTICE SUITS)

(Referred to Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, On account of the increasing number of malpractice suits and the higher malpractice insurance rates, it has become prohibitive for some to continue to practice medicine, including surgery, and for some medical graduates to start a practice; and

WHEREAS, The AMA House of Delegates urged state medical societies to solve the malpractice dilemma on a state basis, rather than leave it for the AMA to do on a national basis; and

WHEREAS, The main reason for vexatious litigation or nuisance suits (not including legitimate cases) is our archaic and unjust state laws which favor the plaintiff at the expense of the defendant, in that a successful innocent defendant in court, whether in a malpractice case or in any other litigation, still has to pay his own attorney's fee and often has a considerable loss in income as a result of having to appear in court; and

WHEREAS, By replacing our unjust, one-sided state laws by a law which makes the plaintiff who falsely accuses a defendant and thus loses his case in court, pay all court expenses including a reasonable fee to the winning party's attorney, such nuisance suits will be deterred; and

WHEREAS, The proposed law is not anything new or original, for this is a law that is on the statute books in most countries of Europe, and effectually restricts litigation to justifiable cases in those lands; and

WHEREAS, The Medico-Legal Committee of the Iowa Medical Society in 1960 did research on an identical resolution introduced by the Marion County Medical Society and decided "that it would be well for the Iowa State Medical Society to give such legislation whatever assistance is deemed practical"; and

WHEREAS, The editor of MEDICAL TRIBUNE AND MEDICAL NEWS (10-2-69) states very well how unjust our present state laws are, by saying that "when a law is distorted to yield cynical profit rather than to secure simple justice, the institution is no longer responding to human needs for better, instead, it is for worse. It has been a sad fact for some years now, that malpractice suits have become a method of squeezing money out of any mishap that can be discovered or invented"; and

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I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction, occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition. Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® (strip pack). Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

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Photo professionally posed.



WHEREAS, This proposed change in our state law must include a provision so that the poor man can sue, if he has a legitimate case, and also a provision as to what state unit shall pay all the costs in case the party in question loses in court; and

WHEREAS, The proposed law should have the active support of the Nurses, Hospital, Manufacturers and Insurance Associations, and we therefore should ask for their active support since this proposed state law will be beneficial to all of them—in fact, to 99 per cent of the people of Iowa; and

WHEREAS, Under the present law most malpractice suits and many other cases are taken on a contingent fee basis. (If the case is won, the attorney usually gets one-third to one-half of the award and if the case is lost, the plaintiff is only out meager court costs and the attorney has lost no more than his time; and

WHEREAS, If the above proposed legislation were enacted, (1) It has been estimated that it would eliminate 80 per cent of our present malpractice suits, and it would also eliminate a large percentage of other litigation. (2) Insurance rates would be lower. (3) Medical costs would be less for the patient since he must pay for this high malpractice insurance. (4) The courts would have more time for legitimate cases. (Some time ago, New York state was four years behind in their court cases.) (5) The plaintiff in justifiable and successful litigation would have his lawyer's fee paid by the defendant; therefore be it

Resolved, That the Iowa Medical Society give its active support toward introducing a bill to the Iowa State Legislature, or support such a bill if it is introduced, that the losing party in litigation shall pay not only court costs but also a reasonable fee to the winning party's attorney, and that there shall also be incorporated in this law a provision that the poor man can sue if he has a legitimate case, and that a definite political unit of the state shall pay all the expenses, if on some occasions the poor man loses in court; and be it further

Resolved, That the Iowa Medical Society write a bill incorporating the objectives of this resolution and embodying in general the procedures employed in most countries in Europe, for an Iowa legislator to introduce.

WOODBURY COUNTY MEDICAL SOCIETY
NO. 4. MEDICARE EXPLANATION OF BENEFITS FORM

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, Patients covered by Medicare whose physicians accept assignment of benefits are provided with a copy of the explanation of benefits form so that they may know the amount of payment to the physician for medical care rendered; and

WHEREAS, Physicians who do not accept assignment are not provided similarly and do not know whether or not the patients have been fairly reimbursed; and

WHEREAS, The Health Insurance Department of the Social Security Administration under section 401.3 (a) (3) (II) of Regulation No. 1 forbids disclosure to the physician of such information; therefore be it

Resolved, That the Iowa Medical Society recommend that the Medicare fiscal intermediary be permitted to provide the physician with a copy of the Explanation Benefits form in instances wherein the physician did not take an assignment, so that he may know when the patient received reimbursement, and review it to determine if proper allowances were made.

DALLAS-GUTHRIE COUNTY MEDICAL SOCIETIES
NO. 5. DIVISION OF THE 5TH COUNCILOR DISTRICT AND CREATION OF A 12TH COUNCILOR DISTRICT

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The Polk-Warren County Society of the 5th Councilor District has a larger membership than many entire districts; and

WHEREAS, Any Councilor appointed outside of the Polk-Warren area is not fully aware of their urban difficulties; and

WHEREAS, A Councilor from Polk-Warren Counties would not be fully cognizant of the needs in the rural area; therefore be it

Resolved, That the 5th Councilor District be divided, by this House of Delagates meeting in Annual Session, into two Councilor Districts, the 5th Councilor District to consist of the present 5th Councilor District exclusive to Polk-Warren Counties. The 12th Councilor District to be composed of the Polk-Warren County Societies; and also

Resolved, That Line 3 of Section 15 of the Constitution shall be changed to read "Delegates shall by Resolution divide the State into twelve geographical councilor districts."

PAGE COUNTY MEDICAL SOCIETY
NO. 6. SPONSORSHIP OF BLUE SHIELD

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, The conditions under which the Iowa Medical Society undertook the sponsorship of Blue Shield have changed; and

WHEREAS, The availability of good health insurance is established; and

WHEREAS, We question the need for a state medical society to be in the insurance business; therefore be it

Resolved, That the Iowa Medical Society cease sponsoring Blue Shield in order to devote its time to matters more relevant to the needs of its members and the health problems of the State.

WAYNE COUNTY MEDICAL SOCIETY
NO. 7. TITLE XIX BILLING

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, The paper work involved for Title XIX has become progressively more onerous; and

WHEREAS, There is no evidence to suggest that the more complicated billing forms have substantially reduced the number of excessive charges; and

WHEREAS, The Government concept of physicians as a group being basically dishonest is repugnant; be it therefore

Resolved, That Title XIX be billed in the same fashion as other patients without resorting to various forms.

SIOUX COUNTY MEDICAL SOCIETY
NO. 8. OPPOSITION TO HIMLER REPORT

(Referred to Reference Committee on Himler Report.)

WHEREAS, The Report of the Committee on Planning and Development (Himler Report) submitted to the AMA convention in Denver, December, 1969, advocates revolutionary changes which would tend to destroy

the freedom necessary for the practice of quality medicine and necessary to preserve what remains of the traditional physician-patient relationship; among these changes being, specifically: (1) Avoiding the use of the terms "private practice," "fee-for-service," and "free choice." (2) "Circumscription of the traditional freedoms of physicians." (3) Developing "uniform and effective methods of auditing for both office and hospital services." (4) Clarifying "the extent to which a physician's responsibility for the privacy of his patient's records will permit him to cooperate in an audit of his office practice"; and

WHEREAS, The general sense of the report places the burden of guilt upon the medical profession and the AMA for shortcomings of political answers to medical problems, and conveys little, if any, of a sense of pride in the vast accomplishments of the profession on both the human and technical levels; therefore be it

Resolved, That the Sioux County Medical Society urgently requests action by the House of Delegates of the Iowa Medical Society opposing the Himler Report and its support for further intervention in the practice of medicine, which can hardly improve the quality of medical care; and urges that these sentiments be relayed to the AMA through the Iowa delegation to the AMA at its Chicago convention.

SCOTT COUNTY MEDICAL SOCIETY
NO. 9. MEMBERSHIP ON EXECUTIVE COUNCIL

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The Executive Council of the Iowa Medical Society consists of the various elected officers; and

WHEREAS, The deliberations and actions of the Executive Council stand to benefit from the broadest possible range of opinion; and

WHEREAS, The Council is deprived of one more voice when a member holds more than one office, each of which calls for a seat on the Council; therefore be it

Resolved, That the Articles of Incorporation be amended, to wit:

On page 8, Section 16, the sentence

"No member shall hold more than one office entitling him to a seat on the Executive Council."

be inserted following the second sentence.

SCOTT COUNTY MEDICAL SOCIETY
NO. 10. MEDICAID PILOT PROGRAM

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, The cost and administration of the current Medicaid program are fraught with confusion, controversy and unpredictability; and

WHEREAS, An insurance-based program would minimize confusion and controversy while making possible a more nearly predictable cost; therefore be it

Resolved, That the Iowa Medical Society, expressing its petition through the American Medical Association, ask the Department of HEW to establish in Iowa a pilot program wherein federal and state Medicaid funds would be used to purchase full coverage insurance from a private carrier, such carrier to be determined by competitive bidding; and be it further

Resolved, That the Iowa Medical Society pledge (1) its utmost vigilance to guard against all abuses of the program and (2) its full cooperation in keeping costs within usual and reasonable limits.

POLK COUNTY MEDICAL SOCIETY
NO. 11. REDISTRIBUTION OF DELEGATES

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, A report of the Ad Hoc Committee to study Iowa Medical Society Councilor Districts, published in the July 1969 JOURNAL OF THE IOWA MEDICAL SOCIETY, reported that, with respect to the number of physicians represented by delegates to the Iowa Medical Society House of Delegates, the ratio varied from one delegate to 4.3 physicians in the Councilor District 10 to one delegate to 22.2 physicians in Councilor District 5, with a total of 147 delegates for 2,370 members, the average ratio being one delegate to 16.1 physicians; and

WHEREAS, A change in the By-Laws of Iowa Medical Society so that Councilor Districts would be the unit of representation rather than counties, with each Councilor District having one delegate and each Councilor District having 25 active or life members being entitled to send one additional delegate for each additional 25 active or life members in good standing (or major fraction thereof), would result in a total of one delegate for Councilor District 10, or one delegate for 36 physician members, and 21 delegates for Councilor District 5 with a ratio of one delegate for 25 physician members; and

WHEREAS, It may seem reasonable to allot to the students of the College of Medicine at the University of Iowa, one delegate, and in addition one delegate to the students of the College of Medicine at the University of Iowa for each 25 members of the Iowa Medical Society who have remained in Iowa from the four previous graduating classes, dating from the time of election; therefore be it

Resolved, That the Iowa Medical Society amend its By-Laws to provide that delegates be selected on a basis of Councilor Districts as described above, with one delegate from each district and an additional delegate from each district for each 25 members (or major fraction) more than an original 25; and be it further

Resolved, That one student delegate be allotted to the College of Medicine at the University of Iowa with an additional delegate to the College of Medicine at the University of Iowa for each 25 members of the Iowa Medical Society who have remained in Iowa from the four previous graduating classes.

Councilor District	*Members 1969*	*Delegates 1969*	*Proposed*
1	101	9	4
2	133	11	5
3	78	9	3
4	198	12	8
5	516	23	21
6	245	14	10
7	570	26	23
8	258	14	10
9	109	10	4
10	36	8	1
11	117	11	5
		147	94

Average ratio 1 delegate to 23 members.

BLACK HAWK COUNTY MEDICAL SOCIETY
NO. 12. SAMA MEMBERSHIP IN IMS

(Referred to Reference Committee on Articles of Incorporation and By-Laws.)

WHEREAS, The interest and understanding engendered in medical students in the policies of organized medicine is enhanced by involvement and participation; and

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*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

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WHEREAS, Such participation should be encouraged both locally and state wide, as well as nationally; and

WHEREAS, Such involvement would also prove means of better dialogue between medical students, medical school alumni and the public; therefore be it

Resolved, That the Iowa Medical Society initiate and sponsor medical student delegates from SAMA to the IMS, specifying that these are to be non-paying, non-voting delegates to the Annual Meeting and assigned to Reference Committees for further participation; and be it further

Resolved, That the University of Iowa Office of Medical Education, in cooperation with the IMS Committee on Medical Education and Hospitals, develop the details as to number of delegates to be selected (suggestion: one delegate from each Councilor District), area of state each delegate is to represent, and selection of IMS delegate to sponsor SAMA delegate; and be it finally

Resolved, That the IMS pattern such sponsorship after such state medical societies which have already instigated such programs, and/or programs of like nature sponsored or to be sponsored by the AMA.

DUBUQUE COUNTY MEDICAL SOCIETY NO. 13. "MINIMUM STANDARDS" FOR "HEALTH INSURANCE"

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, The Iowa Medical Society supports the principle of voluntary "Health Insurance"; and

WHEREAS, Some of the so-called "health insurance sold or advertised in Iowa is virtually worthless by reason of exclusions, limited service coverage, low dollar coverage, time restrictions, exceptions, and various other provisions designed to limit benefits; and

WHEREAS, Such policies are too often promoted by misleading advertising designed to stay within the letter of the law; therefore be it

Resolved, That the Iowa Medical Society be requested to formulate and promulgate a set of minimum standards for "health insurance" of various types, such standards to be basically for the protection of the consumer; and be it further

Resolved, That such minimum standards contain reasonable safeguards against cancellation of a policy for medical reasons, including such practice as frequent renewal periods which give a company frequent opportunity to add exclusions or increase rates in a manner which amounts to cancelling the policy; and be it further

Resolved, That consideration be given to fair labeling of "health insurance" policies, e.g., policies paying less than 80 per cent of covered expenses to be labeled "partial" or "limited" coverage policies, with that fact made clearly apparent both on the policy and in any promotion or advertising pertaining thereto; and be it further

Resolved, That some reasonable and effective means of recourse be provided for a policy holder with a grievance against the insurer; and be it finally

Resolved, That following the formulation of minimum standards for "health insurance," efforts be made to have such standards recognized by appropriate state or national legislation in the interests of the consumer.

DUBUQUE COUNTY MEDICAL SOCIETY NO. 14. MALPRACTICE

(Referred to Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, Nationwide there has been a trend for malpractice claims to increase in size and number, a trend which feeds upon itself; and

WHEREAS, The trend of the courts has been to place an increasing burden on the physician defending himself in a malpractice claim or suit; and

WHEREAS, Litigation is time-consuming not only to the physician himself but to other physicians who are drawn into the litigation; and

WHEREAS, Litigation is a costly process, eventually increasing the cost of medical care; and

WHEREAS, The possibility of malpractice action may at times be responsible for unnecessary tests, x-rays and procedures, thus directly increasing the cost of medical care while reducing the effective utilization thereof; and

WHEREAS, A physician's reputation may suffer unjust damage in litigation or threat thereof; and

WHEREAS, Impetus has already been given in the recognition of these problems by persons in high office, such as U. S. Senator Abraham Ribicoff and Secretary of HEW Robert Finch; and

WHEREAS, It is reported that other states, notably Arizona, have created machinery to alleviate these problems; therefore be it

Resolved, That the Dubuque County Medical Society urge the Iowa Medical Society, in cooperation with or independent of the AMA, to explore ways to improve the legal handling of malpractice claims, in an attempt to curtail unwarranted or excessive malpractice claims and costly litigation through legislative remedy designed to protect both the dignity of the physician and the rights of the patient; and be it further

Resolved, That the Iowa Medical Society be requested specifically to explore the feasibility of creating, through appropriate state legislation, a board, a commission, or other designated body to arbitrate, mediate, effect an equitable settlement of, or otherwise act in securing an equitable disposition of matters involving allegations of malpractice.

SHELBY COUNTY MEDICAL SOCIETY NO. 15. CHIROPRACTIC

(Referred to Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, The Shelby County Medical Society has continually recognized the need for more medical doctors; and

WHEREAS, This need continues, and the need for medical doctors continues to increase; and

WHEREAS, The current license and practice definitions of chiropractic in Iowa are clear and concise and exist for the protection of the general public; and

WHEREAS, The chiropractic schools and chiropractic association have not improved their training and education; and

WHEREAS, The chiropractors lack of training in diagnosis; and

WHEREAS, Chiropractic is not in the best interest of the public; and

WHEREAS, Any change in chiropractic license would not improve medical practice; therefore be it

Resolved, By the Shelby County Medical Society that:

1. We vigorously oppose as a potential threat to the quality of health and health care in Iowa the legislative changes proposed by the chiropractors of Iowa, and

2. The Iowa Medical Society take a firm stand against on this or any legislation to change the practice of chiropractic in Iowa.

DES MOINES AND LOUISA COUNTY MEDICAL SOCIETIES
NO. 16. HYPHENATION OF THE DES MOINES AND LOUISA COUNTY MEDICAL SOCIETIES

(Referred to the Judicial Council.)

WHEREAS, The members of the Des Moines County Medical Society have agreed to the creation of a hyphenated Des Moines-Louisa County Medical Society; and

WHEREAS, The members of the Louisa County Medical Society have agreed to the creation of a hyphenated Des Moines-Louisa County Medical Society; and

WHEREAS, The physicians in other counties have found such asociation mutually beneficial, and such arrangements have been found acceptable to the Iowa Medical Society; and

WHEREAS, The District Councilor has been so informed; therefore be it

Resolved, That the House of Delegates of the Iowa Medical Society meeting in annual session April 1970 approve this hyphenation, but with the understanding that though the physician members thereof intend to meet as a single society, the physicians of each county will maintain a separate representation in the IMS House of Delegates, and retain the right to withdraw from this alliance, should subsequent conditions warrant.

DES MOINES COUNTY MEDICAL SOCIETY
NO. 17. BLUE SHIELD CONTRACT

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, Blue Shield has sent to patients copies of letters to physicians stating that Blue Shield will not pay the fee for a service, thereby inferring to the patient that he does not have to pay any more than Blue Shield allows, even though it is a fee to a private patient; and

WHEREAS, Physicians in this area have had better experience with Medicare as administered in Illinois by a commercial insurance company than they have had with Blue Shield as the fiscal agent in Iowa; therefore be it

Resolved, That Blue Shield be reprimanded strongly for the unethical act of suggesting to patients that they are not obligated to pay a physician's fee for a service even though this is a fee to a private patient; and be it further

Resolved, That the Iowa Medical Society re-examine the advisability of recommending Blue Shield as a fiscal agent for the Medicare program; and be it further

Resolved, That the Iowa Medical Society consider recommending an investigation of the management of Medicare plans by Blue Shield in Iowa.

WEBSTER COUNTY MEDICAL SOCIETY
NO. 18. MEDICARE REASONABLE CHARGES

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, The members of the Webster County Medical Society have patients who receive correspondence from Medicare; and

WHEREAS, The benefits in Medicare are limited; and

WHEREAS, The patients' letters refer to charges rather than benefits; and

WHEREAS, If the charges are discussed the problems are referred to the physician and if benefits are discussed the problems would be referred to the Carrier; therefore be it

Resolved, That the references used in the letters and forms rejecting payment be reviewed and made to conform to the situation involving each claim; and be it further

Resolved, That stereotyped letters not be sent containing phrases like "more than the allowable charge" and that benefits and services be stressed rather than charges.

BOONE COUNTY MEDICAL SOCIETY
NO. 19. MEDICARE PREVAILING FEE DISTRICTS

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, The physicians of this county had their fees reduced by approximately 18 per cent as of January 1, 1970; and

WHEREAS, This reduction brought payments under Medicare and Medicaid to a level below that of the usual and customary charges of 1968; and

WHEREAS, This reduction was done without any notification or explanation either by the Carrier or by the involved government agencies until several weeks after January 1; and

WHEREAS, The expenses of physicians are steadily rising, due mainly to the added paper work resulting from government programs and regulations; and

WHEREAS, There seems to be no satisfactory method of direct communication with the Carrier, or the Department of HEW, or the Department of Social Services regarding this and similar problems; and

WHEREAS, This component Society has considered methods of correcting these inequities through legal action, if necessary; now therefore be it

Resolved, That officers or a Committee of the Iowa Medical Society by their liaison with the Carrier negotiate to correct these problems; and be it further

Resolved, That attention be directed to the so-called districts in which a "prevailing" fee exists and that an appropriate committee study the present districts and make recommendations as to realignment of the districts, so that each area consists of a part of the state which is composed of communities with similar economic and industrial make up.

SCOTT COUNTY MEDICAL SOCIETY
NO. 20. HIMLER REPORT AND MINORITY REPORT

(Referred to Reference Committee on Himler Report.)

WHEREAS, At its 1969 Annual Meeting the AMA House of Delegates received the Himler Report and the Minority Report dealing with long-range planning and development of the organization and functions of the AMA, and

WHEREAS, The AMA requested reactions from component societies on these recommendations, and

WHEREAS, These reports have also been under study by an ad hoc committee of the AMA House of Delegates, and

WHEREAS, The members of this House of Delegates have had the opportunity to review the Himler Re-

port and Minority Report, as well as a summary, and therefore, it can be assumed, are prepared to discuss the respective provisions, now therefore be it

Resolved, That members of this House of Delegates be encouraged to take an active part in the discussion of these documents at the reference committee hearing on this subject, and be it further

Resolved, That, in view of the number and complexity of the issues raised in the Himler Report and the Minority Report, the IMS House of Delegates not be asked to approve or disapprove the report as a whole. Rather, that the IMS Delegates to the AMA function as an ad hoc reference committee where they may listen to and weigh all the opinions expressed on the various portions of the Reports but that they go uninstructed to the AMA House of Delegates where they may consider and vote upon each of the issues rather than try to act upon the Report as a whole.

PLYMOUTH COUNTY MEDICAL SOCIETY
NO. 21. MEDICAL TAPE LIBRARY

(Referred to Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, An immediately accessible source of accurate information on various diseases and their complications would be of great value to the practicing physician and at times might be life-saving; and

WHEREAS, Many Iowa physicians are isolated by time or distance from ready access to sometimes critical medical information; and

WHEREAS, Other medical societies have met this problem successfully by providing a library of tape recordings that deal with most commonly encountered medical problems, such recordings being available for immediate playback over the telephone; therefore be it

Resolved, That the Iowa Medical Society develop or acquire a similar tape library to provide Iowa physicians with immediate, accurate medical information via any dial telephone.

POLK COUNTY MEDICAL SOCIETY
NO. 22. ARCHITECTURAL EDUCATION COMMITTEE

(Referred to Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, Physicians should be leaders in community hospitals and other health facility building projects; and

WHEREAS, The technology and the philosophy of the new designs of all types of architecture changes constantly; and

WHEREAS, The Iowa Medical Society has a responsibility to educate and inform its members in all matters of health care and the delivery of health services; therefore be it

Resolved, That the Iowa Medical Society establish an ARCHITECTURAL EDUCATION COMMITTEE which will:

1. Work closely with the School of Architecture of Iowa State University and other schools of architecture to collect and evaluate the latest ideas and concepts in Hospital and Health Facility Planning.

2. The Committee will acquaint the members of the Iowa Medical Society with these new ideas, concepts and philosophies in hospital and health facility design so that the members will be better informed when called upon to lead in the development of these community facilities.

POLK COUNTY MEDICAL SOCIETY
NO. 23. IMPROVED EMERGENCY CARE SERVICES

(Referred to Reference Committee on Legislation and Miscellaneous Business.)

WHEREAS, The need for improving Emergency Care Services has been repeatedly demonstrated in local and national news media; and

WHEREAS, The Iowa Medical Society has the posture, the Committee structure, and the responsibility to aid in the improvement of Emergency Care Services; therefore be it

Resolved, That the Iowa Medical Society do everything possible to facilitate the following:

1. To design and develop with the appropriate state agencies a program of highway signs for all major Iowa roads which will aid the traveling public in locating
 a. Physicians
 b. Hospital and Emergency Room Facilities
 c. The route through cities and towns to these facilities.
2. Develop a program for the installation of two-way radio communications between ambulances and hospital emergency rooms.
3. Develop a program for the improvement of the status, morale and training of ambulance crews throughout the state.
4. Aid in the development of new ambulance design and new ambulance equipment.
5. Encourage a feasibility study of helicopter service for use throughout the state.

POLK COUNTY MEDICAL SOCIETY
NO. 24. PILOT SATELLITE DIAGNOSTIC AND TREATMENT CENTERS

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, The Iowa Medical Society has always been a leader in improving the quality and quantity of medical care in our state; and

WHEREAS, The Iowa Medical Society has clearly documented the present and projected physician shortage in the State of Iowa; and

WHEREAS, The effectiveness of satellite diagnostic and treatment centers staffed by nurses and physician's assistants and linked to medical centers by two-way closed circuit tele-communication has been clearly established in Boston and other centers; therefore be it

Resolved, That the Iowa Medical Society:

1. Establish a non-profit corporation which will:
 a. Lead in the design, financing and formation of a pilot satellite project between a rural area in need of medical services and a larger medical center.
 b. This corporation is not to provide medical services. It is to aid the two communities in the formation of the satellite and its tele-communication linkage.
 c. This corporation is to report to the Iowa Medical Society at regular intervals as to the effectiveness of the new method of delivering medical services.

WRIGHT COUNTY MEDICAL SOCIETY
NO. 25. GOVERNMENT FEE FIXING

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, In spite of the avowed aim of the IMS to

preserve the so-called Usual and Customary fee principle in dealings with third parties, the same Blue Shield plan sponsored by IMS, Iowa Medicare Part B Carrier, by the obligatory use of the 1968 computer base for U & C, has flaunted that aim; and

WHEREAS, Wilbur Cohen (who made it "obligatory") certainly has not cut *his* fee back to January 1, 1968, nor has the President nor the Congress of the United States, nor any of the officials of HEW, nor, for that matter, have any of the officials of Blue Cross-Blue Shield cut theirs; and

WHEREAS, The political FIXED FEE threat to our Fee for Service method of the private practice of medicine will actually deprive the Sick of this nation of medical care as the Near-sick and Neurotic-well clog all the medical resources; therefore be it

Resolved, That the Iowa Medical Society register its protest against this arbitrary fixing of fees back at the 1968 level in the following strong terms:

1) The sponsorship of Iowa Medical Service (Blue Shield) by the Iowa Medical Society be discontinued.

2) The Iowa Delegates to the AMA be instructed to present a resolution which will issue an ultimatum to HEW and the Congress that the day of inevitable confrontation between them and the doctors of this country is now at hand as they are forcing us to withdraw reluctantly from any participation in Medicare and Medicare-like Title XIX programs.

POCAHONTAS COUNTY MEDICAL SOCIETY NO. 26. BLUE CROSS-BLUE SHIELD RELATIONS

(Referred to Reference Committee on Insurance and Medical Service.)

WHEREAS, Blue Cross-Blue Shield has left much to be desired in its administration of Title XIX and Medicare welfare programs in Iowa; and

WHEREAS, There is apparently no person in Charge of administration of Title XIX or Medicare to which an individual can turn for answers to problems or questions; and

WHEREAS, There continues to be great delays and reductions in payments of these programs without apparent good reason; therefore be it

Resolved, That a vast change be made in Blue Cross-Blue Shield to correct these administrative errors, and that some one individual be assigned to aid in answering these problems in writing for Title XIX and Medicare, and that his name, address, and telephone number be made known!

LIFE AND ASSOCIATE MEMBERSHIPS

LIFE MEMBERSHIP RECOMMENDED ON THE BASIS OF 50 YEARS' PRACTICE AND 30 YEARS' MEMBERSHIP

County	*Name*
Black Hawk	Ralph T. Paige, LaPorte City
Cerro Gordo	Chetwynd M. Franchere, Mason City
Dallas-Guthrie	Allan G. Felter, Van Meter
Keokuk	John Maxwell, Sr., What Cheer
O'Brien	John E. Dahlbo, Sutherland
	Nev E. Weems, Paullina
Polk	Harry W. Dahl, Des Moines
	Lee Forrest Hill, Des Moines
	George S. Marquis, Des Moines
	James C. Mooney, Des Moines
	Harold R. Peasley, Des Moines
Scott	William G. Bessmer, Davenport
Linn	*Frank R. Peterson, Cedar Rapids

* See page 516.

ASSOCIATE MEMBERSHIPS RECOMMENDED ON THE BASIS OF RETIREMENT OR INCAPACITATION

County	*Name*
Cerro Gordo	Harold W. Morgan, Mason City
Hamilton	Faye C. Lewis, Webster City
	William B. Lewis, Webster City
Keokuk	Kenneth L. McGuire, Keota
Kossuth	John N. Kenefick, Algona
Linn	Paul O. Heitzman, Cedar Rapids
	John H. Rieniets, Cedar Rapids
Lyon	Stuart H. Cook, Rock Rapids

The physicians nominated for each of these membership categories were then approved unanimously.

The Speaker then announced the meeting places for the various reference committees and said that they would convene at 2:30 p.m. Delegates were informed that the House of Delegates would convene Wednesday morning, April 29, at 8:00 a.m. in the Grand Ballroom of the Savery Hotel. They were asked to report promptly. The House adjourned at 1:30 p.m.

WEDNESDAY SESSION, APRIL 29, 1970

The Wednesday session of the House of Delegates was called to order at 8:20 a.m. The House approved the taking of attendance by registration cards. There were 111 delegates, 13 voting alternates and 15 ex-officio members present.

County	*Delegate*	*Alternate*
Adair	A. J. Gantz	
Adams		C. L. Bain
Allamakee		C. R. Rominger
Appanoose	E. A. Larsen	
Benton	P. J. Amlie	
Black Hawk	C. D. Ellyson	
	D. E. Conklin	
	Fred Dick, Jr.	
	G. R. Clark	
	L. L. Zager	
Boone	E. E. Linder	
Bremer	V. H. Carstensen	
Buena Vista	Arthur Ames	
Calhoun	R. P. Ferguson	
Carroll	J. M. Tierney	
Cass	K. R. Swanson	
Cedar	G. H. Utley	
Cerro Gordo	A. J. Herlitzka	
	J. Y. Hendricks	
	H. E. Cahoy	
Cherokee	R. D. Berge	
Chickasaw	J. C. Carr	
Clarke	J. D. Kimball	
Clinton	K. R. Sorenson	
	G. R. Schmunk	
Crawford	D. J. Soll	
Dallas-Guthrie	W. A. Castles	
	W. A. Seidler	
Davis	Richard Schoonover	
Decatur-Ringgold	E. E. Gamet	
	D. E. Mitchell	
Delaware	J. E. Tyrrell	
Des Moines	J. F. Foss	
	G. L. Smith	
Dickinson	D. F. Rodawig, Jr.	
Dubuque	R. T. Melgaard	
	K. K. Hazlet	
		J. W. White
Emmet	H. A. Lindholm	
Fayette	R. S. Jaggard	
Floyd	D. L. Trefz	
Fremont	F. M. Ashler	
Grundy	M. P. Vanden Bosch	
Hamilton	G. A. Paschal	
Hancock-Winnebago	L. R. Fuller	
	J. T. Mangan	
Hardin	T. C. Graham	
Harrison	J. W. Barnes	
Henry		W. R. Vaughan
Howard	C. W. Rainy	
Humboldt	Beryl Michaelson	
Ida	J. B. Dressler	
Iowa	D. F. Miller	
Jackson		C. L. Rask
Jasper	R. F. Frech	
Jefferson	G. E. Egli	
Johnson	K. R. Cross	
	C. R. Eicher	
	R. D. Liechty	
	A. S. Norris	
	C. E. Radcliffe	
		R. D. Whinery
Jones	E. H. DeShaw	

County	*Delegate*	*Alternate*
Keokuk	Opas Jutabha	
Kossuth	R. E. Jongewaard	
Lee	J. E. McGee	
Linn	R. M. Chapman	
	J. J. Keith	
	C. R. Aschoff	
	W. J. Robb	
	R. A. Sautter	
Madison		E. G. Rozeboom
Mahaska	G. W. Bennett	
Marion	Peter Van Zante	
Marshall	L. O. Goodman	
	W. T. Shultz	
Mitchell	R. G. Boeke	
Monona	J. L. Garred	
Montgomery	Oscar Alden	
Muscatine	K. E. Wilcox	
O'Brien	J. C. Peterson	
Page	J. R. Gambill	
Pocahontas	J. B. Thielen	
Polk	M. R. Saunders	
	D. J. Walter	
	M. H. Dubansky	
	A. N. Smith	
	J. W. Green, Jr.	
	W. R. Hornaday, Jr.	
	R. E. Hines	
	N. K. Rinderknecht	
	H. E. Wichern	
	J. I. Hostetter	
		H. C. Blount, Jr.
		G. M. Zaharis
		E. J. Hertko
Pottawattamie-Mills	M. E. Olsen	
	Hormoz Rassekh	
	A. L. Sciortino	
	R. K. Fryzek	
Scott	J. F. Collins	
	J. F. Bishop	
	D. A. Bovenmyer	
		R. M. Perkins
Shelby	J. H. Spearing	
Sioux	L. K. Yates	
Story	W. R. Bliss	
	G. E. Montgomery	
Tama		A. J. Havlik
Union-Taylor	R. H. Kuhl	
Wapello	R. P. Meyers	
		L. E. Coppoc
Washington	Elvina N. Martens	
Wayne	K. A. Garber	
Webster	L. J. O'Brien	
	F. D. Lawson	
Winneshiek	T. F. Dynes	
Woodbury	C. L. Beye	
	L. H. Boggs	
	P. M. Cmeyla	
	R. C. Larimer	
Worth	B. H. Osten	

LIAISON DELEGATES

S. P. Leinbach J. M. Rhodes

OFFICERS PRESENT AS EX-OFFICIO MEMBERS OF THE HOUSE

W. M. Krigsten
J. H. Sunderbruch — V. L. Schlaser
T. A. Burcham — K. E. Lister
R. L. Wicks — J. F. Paulson
L. D. Caraway — H. E. Rudersdorf
H. J. Smith — L. W. Swanson
H. L. Skinner — E. M. Smith
C. W. Seibert — R. F. Birge

Dr. Schlaser read the minutes of the April 26 meeting of the House of Delegates, and the House approved them.

Dr. Jerry MacRoberts, president-elect, State Medical Society of Wisconsin, Dr. Delmar Gillespie, president, Minnesota State Medical Association, and Dr. Carl Clark, first vice-president, Illinois State Medical Society, were then introduced by Dr. Caraway and recognized by the House.

The election of officers followed, and the following physicians were chosen:

President-elect	L. J. O'Brien, M.D., Fort Dodge
Vice-president	H. R. Hirleman, M.D., Cedar Rapids
Trustee	J. F. Paulson, M.D., Mason City
Secretary	V. L. Schlaser, M.D., Des Moines
Treasurer	T. A. Burcham, M.D., Des Moines
Speaker of the House	L. D. Caraway, M.D., Monticello
Vice-speaker of the House	H. L. Skinner, M.D., Carroll
Delegate to AMA	H. J. Smith, M.D., Des Moines
Delegate to AMA	L. W. Swanson, M.D., Mason City
Councilor, District 1	C. L. Kelly, Jr., M.D., Charles City
Councilor, District 4	H. E. Rudersdorf, M.D., Sioux City
Councilor, District 6	G. A. Fry, M.D., Vinton
Councilor, District 11	Hormoz Rassekh, M.D., Council Bluffs
Blue Shield Liaison Delegates to IMS	S. P. Leinbach, M.D., Belmond C. W. Seibert, M.D., Waterloo

* Dr. Schlaser then nominated Frank R. Peterson, M.D., of Cedar Rapids, for life membership in the Iowa Medical Society and it was so voted unanimously.

Reference Committee Reports

The following reference committee reports were approved by the House of Delegates.

ARTICLES OF INCORPORATION AND BY-LAWS

The Reference Committee on Articles of Incorporation and By-Laws met at 2:30 p.m. on Sunday, April 26, 1970, to consider the report of the corresponding standing committee and several resolutions. Spirited discussion, joined in by three medical students, was of invaluable assistance to the Committee.

It was pointed out by legal counsel that proposals to amend the Articles of Incorporation and By-Laws should be submitted through the Standing Committee on this subject. Amendments may be presented directly to the House providing the House votes to receive them.

RESOLUTION NO. 9—INTRODUCED BY THE SCOTT COUNTY MEDICAL SOCIETY
MEMBERSHIP ON EXECUTIVE COUNCIL

This Reference Committee requests that the House consent to receive Scott County Resolution No. 9 concerning membership on the Executive Council.

Mr. Speaker, I move that the House grant permission to receive Resolution No. 9.

This Reference Committee feels that the Executive Council is deprived of the broadest possible range of opinion when one of its members holds more than one office each of which entitles him to a seat on the Council. Therefore this Committee recommends that the substance of Resolution No. 9 be adopted with the following resolve substituted for lines 8 through 14:

Resolved, That the Articles of Incorporation be amended by inserting after the second sentence of Article IV, Section 16, the following new sentence:

"No member shall hold more than one office entitling him to a seat on the Executive Council."

Mr. Speaker, I move the adoption of Resolution No. 9 as amended.

EXHIBIT B FROM SUPPLEMENTAL REPORT OF THE STANDING COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

The Standing Committee on Articles of Incorporation and By-Laws noted that in the Articles the Society still lists its place of business as Des Moines. This Reference Committee recommends adoption of Exhibit B from the Standing Committee's Supplemental Report.

EXHIBIT B

Resolved, That the amended and substituted Articles of Incorporation of the Iowa Medical Society, as amended, be and hereby are further amended by striking from Article I the term "Des Moines" and inserting in lieu thereof the term "West Des Moines."

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 5—INTRODUCED BY THE DALLAS-GUTHRIE COUNTY MEDICAL SOCIETIES DIVISION OF THE 5TH COUNCILOR DISTRICT AND CREATION OF A 12TH COUNCILOR DISTRICT EXHIBIT A-3 FROM SUPPLEMENTAL REPORT OF THE STANDING COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

Several studies have been made by Committees of the Society and by some of its component Societies looking toward possible need for redistricting of the Society or some change in the method of determining representation in this House.

Resolution No. 5 from Dallas-Guthrie and Exhibit A-3 of the Supplemental Report of the Standing Committee on Articles of Incorporation and By-Laws both recommend that the present District V be divided into two Districts with one consisting of Polk-Warren and the other consisting of the remaining counties in the present District V. This Committee favors this plan and recommends that, as provided in Exhibit A-3, Polk-Warren be District V and the remaining counties become District XII.

EXHIBIT A-3

Resolved, That Councilor District V be divided into two Councilor Districts, one of which shall be called Councilor District V and consist of Polk and Warren Counties, and the other one of which shall be called Councilor District XII and shall consist of Boone, Calhoun, Dallas, Greene, Guthrie, Hamilton, Story and Webster Counties.

Mr. Speaker, I move the adoption of the foregoing resolution.

EXHIBITS A-1 AND A-2 FROM SUPPLEMENTAL REPORT OF THE STANDING COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

In order to make the changes to accommodate this action, this Committee commends to the House the amendments set forth below. These may be voted upon together, or if you desire, you may divide the question. The suggested amendments follow as proposed in the Supplemental Report of the Standing Committee.

EXHIBIT A-1

Resolved, That the amended and substituted Articles of Incorporation of the Iowa Medical Society, as amended, be and hereby are further amended as follows:

(1) By deleting "11" from Article IV, Section 1, and substituting therefor "12";

(2) By deleting the fourth sentence of Article IV, Section 2 in its entirety, and substituting therefor the following sentence:

"The Councilors shall be elected for terms of three years each, so arranged that the terms of four Councilors shall expire every three years."

(3) By deleting "11" from the first sentence of Article IV, Section 5, and substituting therefor "12";

(4) By deleting "11" from the first sentence of Article IV, Section 15, and substituting therefor "12"; and

(5) By deleting "6" from the fifth sentence of the second paragraph of Article IV, Section 15 and substituting therefor "7."

Mr. Speaker, I move the adoption of the foregoing resolution.

EXHIBIT A-2

Resolved, That the Amended and Substituted By-Laws of the Iowa Medical Society, as amended, be and hereby are further amended as follows:

(1) By deleting "11" from the second and third sentences of Chapter IV, Section 2, and substituting therefor "12" in each such sentence; and

(2) By deleting "11" from the first sentence of Chapter V, Section 14, and substituting therefor "12."

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 11—INTRODUCED BY THE POLK COUNTY MEDICAL SOCIETY REDISTRIBUTION OF DELEGATES

Polk County Resolution No. 11 contained two recommendations which are divided for consideration. The first requested that representation in this House be determined on the basis of Councilor Districts rather than the present basis of counties. Despite some inequality of representation under the current plan, your Reference Committee does not feel that any significant injustices have been wrought by it. On the contrary, the Committee believes that election of delegates on a District basis might concentrate the delegates in the more populous counties leaving the others without representation. Therefore, this Committee recommends disapproval of this portion of Polk County Resolution No. 11.

Mr. Speaker, I move that the first resolved of Resolution No. 11 be disapproved.

The second portion of Polk County Resolution No. 11 suggests a method of representation in this House for medical students from the University of Iowa. Since another portion of this report addresses the matter of medical student participation in this Society this Committee recommends disapproval of this portion of Polk County Resolution No. 11.

Mr. Speaker, I move that the second resolved of Resolution No. 11 be disapproved.

EXHIBITS C-1 AND C-2 FROM SUPPLEMENTAL REPORT OF THE STANDING COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

There has been, over the past several years, a growing move in medicine toward some type of amalgamation with osteopathic physicians and surgeons. The AMA has requested that component state societies join this move by making membership accessible to qualified osteopaths. It seems to your Committee that such union of the professions is desirable and in the public interest. It will permit medicine to participate more fully in the education of osteopathic students and in the training of interns and residents. One must tread warily upon this tender ground to avoid any appearance of blanket indictment but one speaker before this Committee compared the abilities of osteopathic interns with those of some graduates of foreign medical schools. He felt the osteopathic interns were superior in education and performance. For several years, applicants for licenses to practice medicine and to practice osteopathic medicine and surgery have been examined by the same composite board and must pass the same examination. Certainly, during the period of transition to come, there will accrue certain contusions and abrasions. This Committee hopes, with you, that there will be no fractures, concussions, or

major hemorrhages. It should be remembered that these proposed amendments are permissive in nature and not compulsory. It is incumbent upon county societies to decide which, if any, osteopaths they wish to admit.

In an effort to be helpful, this Committee offers the following suggested guidelines to a county society pondering the aplication of an osteopath. He should, as a minimum:

1. Be legally licensed without limitation of practice in the jurisdiction within which he practices.
2. Be willing to abide by the Principles of Medical Ethics of the American Medical Association.
3. Practice scientific medicine.
4. Be acceptable to the credentials committee of the county medical society.

After this somewhat lengthy introduction to the subject, this Reference Committee herewith commends to you the following amendment to the Articles of Incorporation.

EXHIBIT C-1

Resolved, That the amended and substituted Articles of Incorporation of the Iowa Medical Society, as amended, be and hereby are further amended as follows:

(1) By deleting "holding a degree of Doctor of Medicine or Bachelor of Medicine and possessing a valid Iowa license to practice medicine or surgery or to practice as a resident physician"; from Article III, Section 1, and substituting therefor "and resident physicians licensed in Iowa";

(2) By deleting "to practice medicine and surgery who hold a degree of Doctor of Medicine or a Bachelor of Medicine" from Article III, Section 2; and

(3) By adding a new Section 6 to Article III as follows:

"Section 6. 'Physician' as used in the Articles and By-Laws of this corporation shall include physicians and osteopathic physicians and surgeons who hold valid and unrestricted licenses to practice medicine and surgery or osteopathic medicine and surgery. 'Profession' as used herein shall mean the nonsectarian practice of medicine and surgery or osteopathic medicine and surgery by 'physicians.' "

Mr. Speaker, I move the adoption of the foregoing resolution.

This Reference Committee further commends to you the following amendment to the By-Laws of the Iowa Medical Society.

EXHIBIT C-2

Resolved, That the amended and substituted By-Laws of the Iowa Medical Society, as amended, be hereby and further amended as follows:

(1) By deleting "medicine" from the first sentence of Chapter I, Section 6; and

(2) By deleting Chapter I, Section 7 in its entirety and substituting therefor a new Section 7 as follows:

"Section 7. Resident physician membership in this Society shall consist of those practitioners who have a valid Iowa 'Resident Physician License' or a valid Iowa 'Resident Osteopathic Physician and Surgeon License,' who are members in good standing of the component medical societies, who have been so certified at the headquarters of this Society and who have been approved by the Judicial Council. They shall not have the right to vote or to hold office."

Mr. Speaker, I move the adoption of the foregoing resolution.

EXHIBITS D-1 AND D-2 FROM SUPPLEMENTAL REPORT OF THE STANDING COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

Among the other winds of change blowing across the medical scene is the growing feeling that medical students should be drawn into the medical organization. The three students who spoke before this Committee stated that they had no more knowledge of the Iowa Medical Society than did the average layman and that they thus shared with the lay public many of the less favorable impressions of organized medicine. By inclusion in this Society they can learn that its goals are not selfish as they are sometimes labelled. Better acquaintance with the Society and its efforts may influence more students to stay in Iowa for their medical careers. Contacts with practicing physicians will do much to ease the student's transition from academic life to active medical practice. The Society has much to gain, too, from the exchange of ideas and the fresh viewpoints the students can bring.

The students interviewed agreed that a modest assessment of dues would be in order since a thing which has some cost is likely to be valued more highly than something which has none. The matter of dues must be settled by a recommendation by the Board of Trustees to this House for approval.

This Reference Committee recommends approval of the following amendment submitted by the Standing Committee on Articles of Incorporation and By-Laws:

EXHIBIT D-2

Resolved, That the amended and substituted By-Laws of the Iowa Medical Society, as amended, be and hereby are further amended as follows:

(1) By deleting Chapter 1, Section 1 in its entirety and substituting therefor the following new Section:

SECTION 1. Membership in the Iowa Medical Society shall consist of Active, Life and Associate Members as defined by Article III of the Articles of Incorporation and also of Resident Physician members, student members and honorary members. The official roster of members shall be maintained at all times in the office of the Secretary. It shall be composed of the names of those physicians, student members or honorary members certified to the executive office of this Society as provided for by Chapter VI of these By-Laws, and duly approved by the Judicial Council. Registration of the name of a physician, student member or honorary member upon the official roster shall be *prima facie* evidence of his membership and his right to the privileges inherent in that membership."

(2) By renumbering Chapter I, Section 8 as Section 9 and inserting a new Section 8 in Chapter 1 providing as follows:

"Student membership in this Society shall consist of those students in good standing at the School of Medicine at the University of Iowa who are members of the component society authorized to be established for such students, who have been so certified to the headquarters of this Society and who have been approved by the Judicial Council. They shall have the right to vote but shall have no right to hold elective office in the Society."

(3) By deleting the second sentence of Chapter II, Section 1 in its entirety and substituting therefor the following:

"Only registered Active, Student and Life Members may vote on pending questions."

(4) By inserting a new sentence in Chapter III, Section 3 between the third and fourth sentences thereof as follows:

"The component society for Student members shall be entitled to send one delegate for each twenty-five Student members (or major fraction thereof) in good standing as of the close of the preceding calendar year, with the maximum number of delegates set at eight."

(5) By adding a new sentence at the end of Chapter IX, Section 10 as follows:

"The component society for Student members shall be entitled to elect one delegate and one alternate delegate for each twenty-five student members (or major fraction thereof) in good standing as of the close of the preceding calendar year, with the maximum number of delegates set at eight."

(6) By adding a new Section 12 to Article IX providing as follows:

"Nothing in Sections 1, 2 and 3 of Chapter IX shall be construed as preventing the Society from chartering a component society for students in good standing at the School of Medicine at the University of Iowa."

Mr. Speaker, I move the adoption of the foregoing resolution as amended.

(The amendment established the maximum number of student delegates at eight.)

To complete the changes to adapt to student membership, this Committee recommends approval of the following amendment to the Articles of Incorporation as submitted by the Standing Committee:

EXHIBIT D-1

Resolved, That the amended and substituted Articles of Incorporation of the Iowa Medical Society, as amended, be and hereby are further amended by adding the following sentence to Article III, Section 1:

In the event the By-Laws shall provide some form of membership for students in good standing at the Medical School of University of Iowa, a separate component society shall be formed whose membership shall consist solely of such student members.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 12—INTRODUCED BY THE BLACK HAWK COUNTY MEDICAL SOCIETY SAMA MEMBERSHIP IN IMS

This Reference Committee also considered Resolution No. 12 from Black Hawk County concerning SAMA membership in the Iowa Medical Society. Since participation by students in IMS affairs has been offered rather than as set forth in this resolution, this Committee wishes to compliment its sponsors for their vision but recommends that no action be taken.

Mr. Speaker, I move that no action be taken on Resolution No. 12.

The Reference Committee further proposes the following:

Be It Further Resolved, That the Chairman of the Board of Trustees and the Secretary of Iowa Medical Society be and they hereby are authorized and directed to sign, acknowledge and publish the foregoing Amendments as the Eleventh Amendments to the Articles of Incorporation and the Tenth Amendments to the By-Laws of Iowa Medical Society, as amended, and to do all other things required by law or otherwise to execute, complete and place in lawful effect such Amendments.

Mr. Speaker, I move the adoption of the foregoing resolution.

The Chairman wishes to express his thanks to the members of this Committee for their participation. He also extends appreciation to those whose opinions expressed before the Committee were so vital in reaching the recommended conclusions.

Respectfully submitted,
J. F. BISHOP, M.D., *Chairman*
E. E. GAMET, M.D.
J. W. GREEN, JR., M.D.
J. Y. HENDRICKS, M.D.
R. F. FRECH, M.D.

LEGISLATION AND MISCELLANEOUS BUSINESS

The Reference Committee on Legislation and Miscellaneous Business met in open session for nearly three and one-half hours on Sunday, April 26, 1970. A large number of approximately 40 persons who attended the hearing expressed themselves on the various reports and resolutions assigned to the Reference Committee. Full opportunity was given for presentation of information and opinions.

Following the open committee hearing, the Reference Committee met in executive session for approximately one and one-half hours.

Based on the preceding and on its own independent deliberations, the Reference Committee has developed the recommendations contained in this report. It should be pointed out that several of the items assigned to the Reference Committee concern the same subject. As a result, in an effort to avoid being overly-repetitious, the Committee has combined items and recommendations when this seemed feasible.

This Reference Committee report represents the unanimous opinion of its members with the exception of one subject—abortion. There will be a minority report filed by one member of the Committee on this subject.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON LEGISLATION

With respect to federal legislation, your Reference Committee realizes that this is the year when everyone is discussing the cost of health care. There seems to be a larger number than normal of health related bills introduced this year—such items as drug abuse, pollution, inclusion of chiropractic under Medicare, and the new proposed Part C under Medicare are items with which all physicians must concern themselves.

This past year has seen the introduction of numerous bills advocating various means of providing compulsory national health insurance coverage. Included in this area are bills introduced by the AFL-CIO, Walter Reuther's "Committee of 100" and AMA with its "Medicredit" program. These programs may serve as a framework for a lengthy debate on the cost and delivery of health care in the future. These and other bills will require constant attention by our Medical Society officers and staff.

Mr. Speaker, I move the adoption of this portion of the report.

With respect to state legislation, your Reference Committee has discussed the major state legislative items of concern to the Iowa Medical Society and would like to compliment the Committee on Legisla-

tion for its diligent efforts during the recently concluded 63rd General Assembly. This has been a successful and rewarding legislative session as far as the IMS legislative program was concerned.

Your Reference Committee wishes to draw the attention of the House to the greatly increased amount of Society legislative activity resulting from the establishment of annual sessions. Your Reference Committee wishes to commend the efforts of the Committee on Legislation, the legislative contact men, Mr. Robert Throckmorton and the other members of the Society's legislative team.

Your Reference Committee supports the contention that county medical societies and individual physicians need to become well acquainted with their elected representatives. They encourage the idea of inviting legislators periodically to attend meetings of the county and state medical societies. We suggest that the Committee on Legislation be requested to stimulate this practice through its refined LCM program and recommend that each county medical society president be charged with the responsibility of seeing that his legislative contact men are appointed and are active.

Mr. Speaker, I move the adoption of this portion of the report.

Your Reference Committee reviewed each of the some 110 bills of interest to the Iowa Medical Society and asked for comments or suggestions on any of concern to any member. Your Reference Committee would like to commend the Committee on Legislation for its efforts in securing the passage of the Professional Corporations Act (SF 554), the State Crime Laboratory (SF 585) and the other bills of interest to the IMS that were acted upon favorably by this last General Assembly. There were several bills of great interest to the Society that did not receive favorable attention this year. Among these was the Radiation Control bill. The Committee recommends continued interest in this legislation. Your Reference Committee would also like to commend the Committee on Legislation, the legislative contact men and staff for their efforts in the defeat of all proposed chiropractic legislation.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON LEGISLATION

RESOLUTION NO. 15—INTRODUCED BY THE SHELBY COUNTY MEDICAL SOCIETY CHIROPRACTIC-SPONSORED LEGISLATION

Your Reference Committee overwhelmingly agrees with this resolution that states we vigorously oppose as a potential threat to the quality of health and health care in Iowa the legislative changes proposed by the chiropractors of Iowa, and recommends that the Iowa Medical Society take a firm stand against this or any legislation to expand the practice of chiropractic in Iowa. Your Reference Committee agrees that the threat of chiropractic will be a continuing challenge in future legislative sessions and suggests that the Committee on Legislation investigate all possible avenues for the defeat of any future legislation on this subject.

Some suggestions that might facilitate in meeting this challenge are: (1) preparation of a lay brochure presenting the pros and cons on the chiropractic threat to health care which would or could be used in doctors' offices; (2) the education and active participation of paramedical personnel on this subject for legislative support; (3) intensified educational program for member physicians on current chiropractic legislation via the LCM's and Society officers; (4) personal involvement of physicians with legislators at the local level.

Your Reference Committee recognizes that there no doubt will be many bills introduced in future legislative sessions for the expansion of the present chiropractic act and feels that every possible effort should be expended for defeat of this legislation.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON LEGISLATION

RESOLUTION NO. 21—INTRODUCED BY THE PLYMOUTH COUNTY MEDICAL SOCIETY MEDICAL TAPE LIBRARY

Your Reference Committee discussed this resolution, which states the Iowa Medical Society develop or acquire a medical tape library to provide Iowa physicians with immediate, accurate medical information via any dial telephone. It was brought to the Committee's attention that this matter is now under consideration by the Iowa Regional Medical Program as well as adjoining states. Therefore, your Committee feels further study should be done on this subject and recommends this matter be referred to the proper committee of the Society.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF COMMITTEE ON ONCOLOGY

Your Reference Committee has reviewed this report, which suggests the creation of a statewide Cancer Control Commission. It was pointed out that there are several reliable sources for this information at the present time and it was noted that the AMA may appoint an official Committee on Cancer within its organizational structure. Therefore, your Reference Committee accepts this report as informational only and recommends there be no action taken at this time.

Mr. Speaker, I move the adoption of this portion of the report.

HANDBOOK REPORT OF COMMITTEE ON SPORTS MEDICINE PREDICTION OF BODY WEIGHT OF HIGH SCHOOL WRESTLERS

Your Reference Committee wishes to commend the Committee on Sports Medicine for its efforts in regard to determining the proper body weight of high school wrestlers and recommends that the 1970 House of Delegates go on record in favor of endorsing the requested three-year trial period and urge the Iowa High School Athletic Association to adopt the Tipton Weight-Determination Plan in its wrestling program with the following guidelines as quoted in the Handbook: "(1) That trained and paid persons be made responsible for gathering measurements, with a team of 'measurers' formed by each high school conference to serve its member schools; (2) That these measuring teams assume responsibility, following a training clinic, for obtaining the raw data and forwarding the figures to Iowa City for analysis and projection; (3) That a requirement be instituted making it mandatory for any wrestler desiring to compete below his minimal weight to do so only with the approval and under the supervision of a physician (It is estimated that 10

per cent might fall into this category, about 300 of 3,000 prep wrestlers.); (4) That participation in the weight-determination program be made mandatory and that the schools join in underwriting the cost of the service; (5) That the program be instituted on a trial basis."

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON VOLUNTARY HEALTH AGENCIES

Your Reference Committee considered the Committee's suggestion requesting that the Iowa Medical Society develop a program for recognition and certification of voluntary health agencies. The Committee does not feel that it is the right of the Iowa Medical Society to evaluate, recognize or judge these independent agencies. Therefore, it recommends that the Iowa Medical Society continue the policy of complimenting voluntary health agencies for their actions on an individual basis only.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON LEGISLATION

RESOLUTION NO. 3—INTRODUCED BY THE MARION COUNTY MEDICAL SOCIETY
VEXATIOUS LITIGATION (MALPRACTICE SUITS)

RESOLUTION NO. 14—INTRODUCED BY THE DUBUQUE COUNTY MEDICAL SOCIETY
MALPRACTICE

Your Reference Committee realizes that malpractice suits are becoming more of a problem for Iowa physicians each year. However, because there is active interest at the AMA level in this regard, it was felt that the Iowa Medical Society should not initiate definite legislative proposals at this time. Because of this, the Committee recommends that this matter be referred to the Board of Trustees of the Iowa Medical Society for continued close observation and further study.

Mr. Speaker, I move the adoption of this portion of the report, as amended.

(The amendment assigned responsibility for the matter specifically to the Board of Trustees.)

SUPPLEMENTAL REPORT OF SUBCOMMITTEE ON SAFE TRANSPORTATION

RESOLUTION NO. 23—INTRODUCED BY THE POLK COUNTY MEDICAL SOCIETY
IMPROVED EMERGENCY CARE SERVICES

Your Reference Committee accepts this report detailing the implementation of the project providing first aid stations along Iowa's interstate highway system on an informational basis. We would recommend that the House of Delegates commend this subcommittee for their efforts and urge them to pursue all avenues of approach on the improvement of emergency care services.

Your Reference Committee recommends that the House of Delegates adopt the following points contained in Resolution No. 23 improving emergency care services throughout the state: (1) To design and develop with the appropriate state agencies a program of highway signs for all major Iowa roads which will aid the traveling public in locating (a) physicians; (b) hospital and emergency room facilities; (c) The route through cities and towns to these facilities; (2) Develop a program for the installation of two-way radio communications between ambulances and hospital emergency rooms; (3) Develop a program for the improvement of the status, morale and training of ambulance crews on a continuing basis; (4) Aid in the development of new ambulance design and new ambulance equipment; (5) Encourage the Governor of the State of Iowa to institute a feasibility study of helicopter ambulance service for use on a statewide basis.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 22—INTRODUCED BY THE POLK COUNTY MEDICAL SOCIETY
ARCHITECTURAL EDUCATION COMMITTEE

Your Reference Committee recognizes the apparent need for liaison between schools of architecture, architects and leaders in health care and health care delivery in regard to hospital construction. Because of this need, your Reference Committee recommends the formation of an ad hoc committee to study the rules and regulations for the operation and functioning of an Architectural Education Committee which will acquaint the members of the Iowa Medical Society with these new ideas and philosophies in hospital and health facility design. The ad hoc committee would be asked to report their findings to the Executive Council in the near future.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON LEGISLATION

RESOLUTION NO. 1—INTRODUCED BY THE CLINTON COUNTY MEDICAL SOCIETY
IOWA STATUTE REGARDING ABORTION

RESOLUTION NO. 2—INTRODUCED BY THE SCOTT COUNTY MEDICAL SOCIETY
IOWA STATUTE REGARDING ABORTION
THE SUPPLEMENTAL REPORT OF THE SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH
IOWA STATUTE REGARDING ABORTION

Your Reference Committee carefully considered the position adopted by the 1968 House of Delegates with respect to the question of Iowa's statute regarding abortion. It is readily apparent that exhaustive and sincere thought has been given the matter by the physicians of Iowa. The assessment of your Reference Committee has included a review of the Society's involvement in the recent efforts to liberalize the state's abortion statutes; it also has included an evaluation of the comments which have come to the Society during this period, and further it has included an analysis of remarks made at the open hearing this year and the deliberations in past years.

After carefully evaluating these factors, your Reference Committee submits the following substitute resolutions in lieu of Resolutions 1 and 2 and the Supplemental Report of the Subcommittee on Maternal and Child Health:

Resolved, That the Iowa Medical Society be on record in favor of new legislation that would leave the matter of the termination of a pregnancy between the woman and her physician.

Resolved, That such legislation be in accordance with the following guidelines: (1) The termination of a pregnancy shall only be performed by a physician and surgeon licensed to practice in the State of Iowa; (2) The procedure shall only be done in a hospital; (3) No physician, hospital or hospital personnel shall be required to participate in the termination of a pregnancy; (4) Provisions shall be made so that no legal action can be taken against any hospital or person refusing to administer services relating to these procedures.

Resolved, That the Iowa Medical Society should lend its knowledge and assistance, when called upon, in support of legislation on this subject, using the above-named guidelines.

Mr. Speaker, I move the adoption of the foregoing substitute resolutions.

(The following minority report was presented by Dr. H. E. Rudersdorf.)

(A division of the vote on the concluding motion in the majority report was requested and the result was 75 in favor and 25 opposed.)

Mr. Speaker, I move the adoption of this report as a whole, as amended.

Respectfully submitted,
H. E. WICHERN, M.D., *Chairman*
C. D. ELLYSON, M.D.
A. S. NORRIS, M.D.
H. E. RUDERSDORF, M.D.
D. J. SOLL, M.D.

MINORITY REPORT—LEGISLATION AND MISCELLANEOUS BUSINESS (SECTION ON ABORTION) SUPPLEMENTAL REPORT OF THE COMMITTEE ON LEGISLATION

RESOLUTION NO. 1—INTRODUCED BY THE CLINTON COUNTY MEDICAL SOCIETY IOWA STATUTE REGARDING ABORTION

RESOLUTION NO. 2—INTRODUCED BY THE SCOTT COUNTY MEDICAL SOCIETY IOWA STATUTE REGARDING ABORTION

THE SUPPLEMENTAL REPORT OF THE SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH IOWA STATUTE REGARDING ABORTION

We are not insensitive to the majority report and we respect the expression of its manifestations of human concern. This is one of the marks of a good physician. But will the proposed abortion changes serve the common good? Experience in other countries, i.e., Scandinavia, Eastern Europe and Japan, has not shown this to be true.

Now is the time for honest disagreement and considered judgement. Thanks to our democratic society and the democratic processes of the Iowa Medical Society, we are assured this freedom to disagree. I and others have the right, even the obligation, to state our convictions and warnings clearly and honestly for the record here and, more importantly, for the good of the patient.

Abortion is not therapeutic—it does not cure. The fetus is destroyed, the immediate problem of the mother is relieved—potentially able to return and return and return. There must be a better answer than just treating a symptom.

What are the goals of the medical profession? Are they not the preservation and fostering of life? Are the suggested means consistent with this goal? Are there other options? Is this the best option or are there better ways to preserve and foster life? Are we considering only our present time? What about the future? Can we profit by mistakes of the past? Medical knowledge half life is now five to seven years. The facts we accepted a few years ago have changed completely with recent scientific discoveries. We do have alternatives. Let medicine use its traditional positive or constructive concepts of therapy.

ALTERNATIVE TO LIBERALIZED ABORTION

What can be done to meet the problem? Many possibilities present themselves. Most are under way and could be expanded or modified.

1. Provide a sensible education program, offered at the elementary, secondary and college levels, and geared to the interests and needs of the children, presenting information about sexual relations and family life.
2. Intensify efforts to discover and perfect more reliable and more economical methods of birth control, acceptable to persons of various religious convictions. According to Dr. Guttmacher, abortion-on-demand makes a very ineffective contraceptive program.
3. Modify the Hospital Abortion Committee into abortion prevention committees, with social worker, lawyer representatives, and physicians to the extent possible in Iowa, and authorize them to function broadly, affirmatively, constructively in keeping with their new title.
4. Support and expand medical research on causes, preventive measures, and treatment of mental and physical abnormalities of unborn children and infants.
5. Provide appropriate and adequate economic assistance to self-supporting mothers who may be uncomfortably close to poverty conditions.
6. Conduct consistent, in-depth research on the causes of success and failure in marriage. Pending or recent divorce has been recognized as a major contributing cause of demand for abortions.
7. Modify marriage licensing laws to provide a cooling-off waiting period, thus blocking hasty marriages which too often end in hasty divorce—sometimes after conception of a child. Possibly require evidence of completion of a simple family management course, coupled with an appropriate test.
8. Affirmatively encourage adoptions if the mother does not want her child; in the alternative, provide suitable foster homes.
9. Generally, through education, legislation and publicity, encourage wholesome respect for family life, pregnancy and childbirth.
10. Review and appropriately revise legislation designed to prevent distribution of pornographic literature and other forms of public entertainment which unduly arouse libidinous instincts and may tend to encourage illicit sexual relationships.

WILL WE ACHIEVE ADVANTAGES IN LEGALIZING THE ABORTION LAW BY THE MAJORITY REPORT

Liberalization will not reduce the criminal abortion rates. In European countries and Japan the massive increase of legal abortion has not rid the countries of their illegal abortion problem which occurs at a rate of 9 to 13 per cent. Furthermore, in these countries patients can obtain an abortion at hardly any cost.

There is an approximate 10 per cent rate of moderate or severe psychiatric sequelae following abortion.

Two of the justifications for killing—war and capital punishment—are being increasingly questioned in public debate at the same time that liberalization of abortion laws are being proposed. Murder, to be defined more specifically, is the killing of innocent life.

Over the 16 year period of 1950-1966, according to the report of the Minnesota Maternal Mortality Committee, there were 21 criminal abortion deaths and 1,301,745 live births in the state of Minnesota. This is one of the few figures available in the United States at the present time. If we use this figure at the rate of 3.5 million live births per year in the United States, extrapolation will lead us to a figure of sixty criminal abortion deaths per year in the entire United States and not 8,000 criminal abortion deaths as suggested by the proponents of liberalization.

Is it easier to feel that abortion is being performed for the sake of the fetus; honesty requires us to recognize that we perform it for the mother.

Alleged rapes require only the willingness of the patient to consult a physician within five days of the occurrence. To many physicians this would permit the performance of uterine curettage before implantation has occurred, which is already legal and would have several advantages. Rape and incest are only a minor part of the total. If necessary, only this segment of the law could be changed.

Abortion-on-demand is a social situation, not a medical decision. The patient does not now come into the office and state "I want my appendix removed." This situation will leave the physician at the mercy of the woman who decides on an abortion and then pleads psychiatric reasons which are now 75 to 80 per cent of present day indications. The decision would be entirely up to those two people, both of whom are under stress. The physician will be only a tool used to gain a temporary remedy to a social-economic problem.

We realize that a large percentage of the public and physicians want some change in the state abortion law, but most do not want an abortion-on-demand law. The public looks to the physician for guidance and good judgement to a long-range remedy, not just expediency.

Why go further than the legislators? This decision enters the profession into one of the blackest periods ever, and may be a tool to complete domination of the individual by the state, i.e., limitation of the size of family to two children, and limitation of the duration of life-euthanasia.

The irony of tens of millions of dollars being spent to improve the lot of the newborn from the time of conception is overwhelming in the light of our present considerations.

We talk so much of discrimination, but the fetal's rights must be considered, not just the mother's rights. They cannot be completely ignored by an edict that says they no longer exist.

Britain's experience shows the shape of things to come. It seems apparent that when "mental health" and "total environment" clauses are included, problems are certain to arise.

Gynecologists find themselves spending half their office hours passing judgement on patients seeking abortions and half their operating time in performing them. With the same type of law, do we seriously expect conditions to be different in North America?

In the British House of Commons at the crucial second reading of the Abortion Act of 1967, there were only 29 votes against the Bill. Recently, an amendment to tighten the Abortion Law was only defeated by a vote of 210 to 199. When the Abortion Act of 1967 was introduced, most physicians favored it. But in a recent poll of 5,000 doctors, 62 per cent of physicians felt the law should be tightened.

Furthermore, these countries have national health services so that patients can obtain abortions at hardly any cost. What would happen in the United States where the cost of an abortion to the private patient, including the cost of the hospital and physician, would be in the neighborhood of several hundred dollars. The poor would not be able to afford this expense. One might then visualize the necessity again to avoid discrimination of a national program, which we suppose we would call "Aborticare." And how would private medical insurance plans handle this one? Pregnancy coverage figures can be calculated when the approximate duration of the average pregnancy is known. How many abortions per year would we permit under private or state insurance plans? Neither the hospital nor the physician can anticipate doing this procedure free of cost.

CONCLUSIONS

We urge that until we find some valid data, that until we have some documented size of the problem here in Iowa, that we stay conservative (not just vocal heat by a vigorous minority).

We urge that the flood gates are never opened for they can never be closed again on this issue. The Iowa Medical Society can live with the 1968-1969 House of Delegates' stand which has never had a chance with legislature.

We urge those who are yet uncommitted to consider the facts, the fetus, and the British experience. At this point in time, it would be well to remember that old obstetrical adage, "First do no harm."

Therefore, I move, as a substitute for the motion of a majority of the Reference Committee, that the House of Delegates reaffirm its stand regarding abortions taken in 1968 and 1969.

Respectfully submitted,
H. E. RUDERSDORF, M.D.

(The minority report was accepted for information only inasmuch as the motion contained in the concluding paragraph was defeated.)

COMMITTEE ON HIMLER REPORT

A special Reference Committee on the Himler Report met in open session Sunday, April 26, 1970, to receive testimony from interested delegates and members on this important and complex topic. Approximately 25 physicians, including spokesmen for Resolutions 8 and 20, participated in the two-hour discussion.

For the background information of this House of Delegates, at the 1969 Clinical Meeting of the American Medical Association House of Delegates, a major report (The Himler Report) was submitted by the Committee on Planning and Development of the AMA Board of Trustees; accompanying this was a Minority Report submitted by John H. Budd, M.D., of Ohio.

The aforementioned AMA Committee on Planning

and Development, under the chairmanship of George Himler, M.D., of New York, was charged: "(1) to study and make recommendations concerning the long range objectives of the Association and the resources, programs and organizational structure by which the Association attempts to reach them; (2) to serve as a focal point for the planning activities throughout the Association, and (3) to study, or cause to be studied, medicine in the environment in which the Association must function, and transmit the conclusions of these studies, in the form of recommendations, to the Board of Trustees for distribution to appropriate decision making centers throughout the Association, particularly the House of Delegates."

The Board of Trustees of the AMA presented this report to the 1969 Clinical Meeting of the House of Delegates. It contained 18 groups of far ranging recommendations, totalling 57 in number. The previously mentioned Minority Report was also submitted with a partial listing of 19 recommendations.

The following three actions were taken by the 1969 AMA House on these reports after extensive debate: (1) That a permanent Long Range Planning and Development Committee should be appointed; (2) That an Ad Hoc Committee on Long Range Planning and Development should receive all material (the Majority Report and the Minority Report) relating to the project and make recommendations concerning the structuring of and the charge of the permanent Committee on Long Range Planning and Development; and (3) That recommendations based on the Majority Report and the Minority Report be brought before the AMA House of Delegates in the form of specific resolutions.

The previously-mentioned Ad Hoc Committee will present a report to the AMA House of Delegates in June, and it will be considered along with those resolutions which may be introduced by the state societies.

At the open hearing held by your Reference Committee on Sunday, April 26, the participants in the discussion agreed that certain parts of the Majority Report deserve to be considered further. There was additionally strong support for the Minority Report and agreement that it does raise valid questions and objections to the recommendations in the Majority Report. There seemed to be concurrence that action on the various recommendations should be taken individually and after separate consideration.

In view of the sentiment expressed at the hearing, your Reference Committee believes this House of Delegates would be best advised to adopt the second Resolve of Resolution 20, and it does therefore recommend approval of the following:

"*Resolved*, That, in view of the number and complexity of the issues raised in the Himler Report and the Minority Report, the IMS House of Delegates not be asked to approve or disapprove the report as a whole. Rather, that the IMS Delegates to the AMA function as an ad hoc reference committee where they may listen to and weigh all the opinions expressed on the various portions of the Reports but that they go uninstructed to the AMA House of Delegates where they may consider and vote upon each of the issues rather than try to act upon the Report as a whole."

Mr. Speaker, I move the adoption of this portion of the report.

Consistent with the preceding, your Reference Committee recommends that Resolution 8 be not adopted.

Mr. Speaker, I move the adoption of this portion of the report.

Mr. Speaker, I move the adoption of this report as a whole.

Respectfully submitted,
L. W. SWANSON, M.D., *Chairman*
E. M. SMITH, M.D.
H. J. SMITH, M.D.
C. E. RADCLIFFE, M.D.

REPORTS OF OFFICERS

The Reference Committee on Reports of Officers met in open session at 2:30 p.m. on Sunday, April 26, 1970 to consider Sections I, IV, and V of the Supplemental Report of the Board of Trustees. The reference committee reacted favorably to these reports, and the following recommendations are offered to the House of Delegates for its consideration and action.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES SECTION I—GENERAL ACTIVITIES

A review of this section of the Board of Trustees' Supplemental Report demonstrates the wide range of activities in which the Iowa Medical Society is engaged. The Board should be commended for the time and effort it expends in overseeing all aspects of Society affairs.

In reference to the portion of Section I regarding scientific programs, the committee recommends that the Board of Trustees be encouraged to continue to investigate the feasibility of joining with some or all of the other states in the North Central Medical Conference in arranging annual scientific sessions, apart from business sessions; further that in exploring this matter, an effort be made to schedule a multi-state scientific meeting as a pilot project. In this regard, the committee agreed that in an effort to stimulate physician interest in attending such a program, consideration be given to selecting a meeting site that would have adequate recreational facilities.

The Committee agrees with the Board of Trustees that a study of possible reorganization of the House of Delegates be delayed until there has been opportunity for the states in the North Central Medical Conference to express a negative or positive attitude with respect to joining together for annual scientific sessions.

Mr. Speaker, I recommend adoption of this portion of the report.

The excellent relationship that exists between the IMS and the University of Iowa College of Medicine was acknowledged, as declared by both the Board of Trustees and Dr. Robert C. Hardin, Vice President of Health Affairs at the University. Certainly, every effort should be made to maintain and strengthen liaison and rapport with Dr. Hardin, with members of the faculty, and with the new Dean of the College of Medicine, Dr. John Eckstein.

The Society's Committee on Medical Education and Hospitals is also encouraged to continue to work with the College of Medicine in fostering and promoting postgraduate medical education programs for physicians in the state.

Mr. Speaker, I recommend adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES SECTION IV—FINANCES

All members should take pride in the attractive and functional office facilities of the Society, and it is with pleasure that the Reference Committee notes that the accelerated payoff schedule on the building re-

mains unchanged, the final payment due in 1972.

The Board's recommendation that the dues in 1971 be established at the present level was met with great enthusiasm by the Reference Committee, and it is wholeheartedly endorsed.

Attention was given to the financial plight of the JOURNAL OF THE IOWA MEDICAL SOCIETY. Thanks to the direction of Dr. Dennis Kelly, Sr., Scientific Editor, and staff, it has become a well-respected and prestige publication; however, because of a reduction in pharmaceutical advertising, which is nationwide in scope, revenue has also decreased. The Reference Committee recommends that the Board of Trustees continue to explore methods to consolidate printing and other expenses in an effort to reduce the overall cost; further, that the Board of Trustees be given authority to experiment with the format of the JOURNAL in an effort to increase interest in it by both the profession and the public, and to correct the fiscal imbalance.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES SECTION V—FOUNDATION FOR MEDICAL CARE

The Reference Committee expresses great enthusiasm for the proposal of the Board of Trustees relating to the creation of a Foundation for Medical Care in Iowa, and commends the Board for its foresight in making this proposal. The Committee underscores the statement that "the Foundation approach might be the most practical and workable system for the medical profession to oversee services provided by its members, to fulfill the professional obligation of providing quality medical care as economically as possible and to assure that services are being properly utilized." A natural by-product will undoubtedly be an improvement in the delivery of medical care to our patients.

The Reference Committee strongly recommends that the House of Delegates direct the Board of Trustees to:

1. Proceed with an in-depth feasibility study of establishing a Foundation for Medical Care in Iowa, including all of the ramifications—legal and otherwise—that such a program might entail.

2. Arrange a series of meetings throughout the state late this summer and/or early fall to familiarize all members of the Society, but especially the delegates, with information about the structure and operation of a Foundation for Medical Care.

3. Submit specific recommendations regarding the creation of a Foundation for Medical Care in Iowa to the House of Delegates at the earliest possible time, in special session if necessary.

Mr. Speaker, I move the adoption of this portion of the report.

Mr. Speaker, I move the adoption of this report as a whole.

Respectfully submitted,
C. R. ASCHOFF, M.D., *Chairman*
TERRY DYNES, M.D.
PAUL FERGUSON, M.D.
J. F. FOSS, M.D.
A. N. SMITH, M.D.

JUDICIAL COUNCIL

The Judicial Council on April 15, 1970, considered Resolution No. 16 requesting hyphenation of the Des Moines-Louisa County Medical Societies. The Resolution has the approval of both societies.

The House of Delegates by unanimous consent agreed that the Judicial Council need not convene during the House of Delegates to consider this Resolution and its action on April 15 would be reported to the final session of the House of Delegates.

The Judicial Council recommends approval of Resolution No. 16.

Mr. Speaker, I move the adoption of this portion of this report.

Mr. Speaker, I move the adoption of this report as a whole.

Respectfully submitted,
J. F. BISHOP, M.D., *Chairman*
C. L. KELLY, JR., M.D.
H. G. MARINOS, M.D.
J. M. RHODES, M.D.
H. E. RUDERSDORF, M.D.
H. E. WICHERN, M.D.
G. A. FRY, M.D.
L. D. CARAWAY, M.D.
E. A. LARSON, M.D.
E. E. GAMET, M.D.
OSCAR ALDEN, M.D.

INSURANCE AND MEDICAL SERVICE

The Reference Committee on Insurance and Medical Service met in open sesion for more than three hours on Sunday, April 26, 1970. The Committee considered six reports and 11 resolutions.

Many items referred to the Committee dealt with the same subject matter. The Reference Committee made an attempt to combine some of the reports and resolutions, but feels, in the interest of clarity, comment is needed on each individual report and resolution as presented.

The Reference Committee is disappointed that, in many instances, no delegate was present from the county society introducing a resolution to clarify points that were not clear to members of the Reference Committee or those present at the opening hearing. The Reference Committee recommends that delegates make a special effort to attend Reference Committee hearings and be prepared to comment on resolutions that have been submitted for action.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES MEDICARE—MEDICAID—PEER REVIEW—SECTION II

This report in part dealt with the 1968 "fee freeze" imposed by HEW on Medicare. The Iowa Medical Society was instrumental in organizing strong objection to this unilateral and unfair regulation and registered protest through the American Medical Association and directly with HEW. The regulation, even though less stringent than originally contemplated by HEW, is still completely unacceptable to the physicians of Iowa.

The Reference Committee commends the Board of Trustees for past efforts in combating attempts by the federal government to further control the private practice of medicine. The Board of Trustees should continue active pursuit of measures to reduce the infringement of government on the practice of medicine.

Mr. Speaker, I move the adoption of this portion of the report.

The Reference Committee regrets that Iowa physicians were not notified of the impending "freeze" on medical care fees under Medicare prior to actual im-

plementation on January 1, 1970. The Reference Committee recommends that the Iowa Medical Society through its liaison with the Carrier assure when possible that physicians receive prior notice of any impending changes in regulation authorized by Medicare.

Mr. Speaker, I move the adoption of this portion of the report, as amended.

(The amendment directed that all regulatory changes be brought to the prior attention of Iowa physicians.)

Many physicians at the hearing expressed concern that even with the excellent liaison between the Iowa Medical Society and Blue Shield and the same excellent relationship with officials of the Department of Social Services, the voice of physicians on matters relating to governmental programs seems to be diminishing. Continued vigilance is needed to maintain the physician-patient relationship in all third-party programs. Individual physicians also need to redouble their efforts to preserve the physician-patient relationship and deal directly with their patients for the payment of medical care when and wherever feasible.

Mr. Speaker, I move the adoption of this portion of the report.

The Board Report comments on the strengthened Iowa Medical Society peer review program, particularly as it relates to the review of Medicaid billings for physicians who received 1968 payments from Medicaid in amounts in excess of $15,000. The Reference Committee is impressed with the fairness and objectivity of the peer review program. The Committee recognizes that the use of any specific dollar payment received by a physician as a guideline for peer review is unfair and inadequate. It is recognized that the original Medicaid review was, out of necessity, completed in a very short period of time.

The Reference Committee recommends that all Medicaid, Medicare and Blue Shield Claims be reviewed under the existing Quality Assurance program and not be selected for peer review solely on the basis of dollar amount paid to a physician.

Mr. Speaker, I move the adoption of this portion of the report.

The Reference Committee recommends strong support of the peer review program to assure all parties that the Society wishes to make available its expertise and manpower in a manner that best serves the health care needs of Iowa citizens.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES
BLUE SHIELD REPORT—SECTION III
REMARKS OF C. V. EDWARDS, SR., M.D.,
CHAIRMAN, BOARD OF DIRECTORS, IOWA MEDICAL SERVICE
REMARKS OF S. P. LEINBACH, M.D.,
PRESIDENT, IOWA MEDICAL SERVICE

These three reports vividly point out that in its role as a private pre-payment program and as administrator for Medicare and Medicaid, Blue Shield handles payments for physicians' services involving approximately 50 per cent of Iowa citizens. This fact alone is one reason physicians express concern with regard to administrative difficulties that relate to these various programs. It is obvious that some physicians do not separate Blue Shield's role as a private pre-payment program from Blue Shield's role in the Medicare-Medicaid programs. The Reference Committee is pleased that excellent liaison exists between the Iowa Medical Society and Blue Shield and suggests that this liaison be made even stronger in an increasing effort to reduce the number of physician complaints received regarding Blue Shield's involvement in third party payment.

Mr. Speaker, I move the adoption of this portion of the report.

The three reports on Blue Shield demonstrate that communications is still one of our most perplexing problems. The Reference Committee recommends that joint meetings between the Board of Trustees of the Iowa Medical Society and the Blue Shield Board of Directors Executive Committee continue to be held on a regular basis in an effort to reduce any communication gap that may exist between Blue Shield, the Iowa Medical Society and individual physicians.

Mr. Speaker, I move the adoption of this portion of the report.

The reports of the Blue Shield President and Chairman of the Board refer to many items which illustrate Blue Shield's willingness to implement actions of this House of Delegates. These relate to coverage which encourages the use of out-patient and private office facilities and a continued reduction in low-level payment contracts with conversion to high-level contracts. The Reference Committee recommends that Blue Shield continue to make further strides in providing comprehensive coverage to Iowa citizens.

Mr. Speaker, I move the adoption of this portion of the report.

The Reference Committee was disappointed to learn that the UCR (usual, customary and reasonable) program has not been approved for sale to intra-state subscribers. The UCR program is available in Iowa only to national accounts (those involving subscribers in more than one state). This House of Delegates when it approved the usual, customary and reasonable program for sale in Iowa did so, in part, to eliminate the differential in payment to participating and non-participating physicians that exists in the comprehensive contract. Blue Shield should actively pursue with proper authorities the approval of the UCR contract.

Mr. Speaker, I move the adoption of this portion of the report.

The Reference Committee wishes to call two aspects of the UCR contract to the attention of the House. The contract includes a provision known as the "hold harmless" clause. This provision calls on the physician, be he participating or non-participating, to accept Blue Shield payment as payment in full. Any disagreement on the fee is to be resolved between the physician, Blue Shield and/or the Iowa Medical Society peer review mechanism. The "hold harmless" provision does not apply in instances where the physician has an advance understanding with the patient for payment of the full charge regardless of subsequent payment by Blue Shield. This concept is an important one which is endorsed by this House of Delegates, but the Reference Committee feels the House should be reminded of this provision in the UCR contract.

Mr. Speaker, I move the adoption of this portion of the report.

The second aspect of the UCR contract which the Committee wishes to call to the attention of the House deals with the term "reasonable." Through experience it has been discovered that the use of the word "reasonable" often leaves an incorrect impression both with the physician and patient. Where payment is rendered which is less than the physician's charge the

patient often assumes that if the payment is not "reasonable" it is therefore "unreasonable." The Reference Committee recommends that Blue Shield in consultation with the Iowa Medical Society explore the possibility of a substitute term which describes the actual concept of "reasonable" but is more acceptable to all parties.

Mr. Speaker, I move the adoption of this portion of the report.

The Blue Shield President's report stated that payments under Medicaid were reduced in 1969 to 4.8 million compared to 5.5 million in 1968. A similar reduction occurred in Medicare Part B. It was pointed out that 1968 payments did in fact represent many claims for services rendered in 1967 which were not paid until 1968. The Reference Committee feels the House of Delegates should be aware of these facts.

Mr. Speaker, I move the adoption of this portion of the report, as amended.

The Reference Committee on several occasions heard testimony regarding the fee freeze imposed by HEW based on 1968 fee data. It is obvious this data includes billings for services rendered in 1967. Prevailing charges computed on this data would include some 1967 charges as well as 1968 charges. The federal government has indicated that Carriers may be permitted on July 1, 1970, to update prevailing charges based on 1969 data. Recognizing that the Carrier has paid many claims in 1969 for services rendered in 1968 the Reference Committee recommends that, if possible, the Carrier purge from its records 1969 payment data for services rendered in 1968. It is understood this would be subject to HEW approval. However, if the government wants to restrict fees to the 1969 level, such restrictions should be based only on 1969 charges.

Mr. Speaker, I move the adoption of this portion of the report.

The Reference Committee notes extreme frustration on the part of physicians as to the inability of providers of care to adequately influence regulations emanating from the federal government. It seems the executive branch, as represented by HEW, fails to fully appreciate that many of its regulations tend to discourage physicians from participating in Medicare and Medicaid. This can only result in increased misunderstanding between the patient and the physician and reduce the availability of medical care. This does not represent the intent of Congress as it enacted Medicare and Medicaid. The Reference Committee feels the Iowa Medical Society, American Medical Association, Blue Shield and the National Association of Blue Shield Plans should strongly voice both individually and collectively the concern of physicians with regard to the increased interference by the federal government in the physician-patient relationship. The Reference Committee recognizes the difficulty of this task, but encourages the Society to do everything at its command to bring to the attention of all parties the position of Iowa physicians in this regard.

Mr. Speaker, I move the adoption of this portion of the report.

The Reference Committee was pleased to learn that Blue Shield has undertaken a pilot program in a western Iowa clinic wherein the clinic actually codes the claims submitted to Blue Shield. This should greatly reduce the number of administrative errors on physicians' billing forms. Refinements in the coding of claims should increase the accuracy of physicians' fee profiles and the determination of prevailing charges under the various Blue Shield and governmental programs. The Reference Committee recommends that the Iowa Medical Society and Blue Shield undertake a program which encourages physicians to implement the coding of claims in their offices using the Blue Shield Coding and Nomenclature Manual which is available to all physicians. Efforts to encourage all third parties to utilize the same coding and nomenclature system is indicated.

Mr. Speaker, I move the adoption of this portion of the report.

The National Association of Blue Shield Plans in a recent action recommended that it function as the prime contractor for all Blue Shield plans in dealing with government on medical care programs. The Reference Committee recognizes that government deals with Medicare Carriers on an individual basis which could tend to dilute effective negotiation on provisions of Carrier contracts. The possibility of NABSP serving as a negotiating force on government contracts may have virtue, but the Reference Committee agrees with the President of Blue Shield that this may also pose serious questions.

Physicians have long functioned through the voice of local and state medical societies plus the American Medical Association. Any governmental program for the provision of medical care must continue to be formulated with the advice and consultation of organized medicine as established through policy of local and state medical societies plus the American Medical Association.

Mr. Speaker, I move the adoption of this portion of the report.

SUPPLEMENTAL REPORT OF SUBCOMMITTEE ON PUBLIC ASSISTANCE (REPORT OF THE IMS REPRESENTATIVE TO THE MEDICAL ASSISTANCE ADVISORY COUNCIL TO THE DEPARTMENT OF SOCIAL SERVICES)

The first item of this report deals with a proposal by the Department of Social Services relating to a maximum payment for routine physical examinations under the Medicaid program. The Reference Committee believes that if the Department does not wish to pay for routine preventive services, this should be stated as Medicaid policy. The Committee strongly objects to the establishment of any set maximum fee for a routine physical examination. The Reference Committee recommends that the House reaffirm its position of usual, customary and reasonable fees under all third party programs.

Mr. Speaker, I move the adoption of this portion of the report.

If the Department of Social Services finds that physicians and patients are possibly abusing the Medicaid program as it relates to routine physical exams and laboratory procedures, efforts should be made to locate specific abuse through the Quality Assurance program and these cases should be referred to the appropriate peer review committee.

Mr. Speaker, I move the adoption of this portion of the report.

L. J. O'Brien, M.D., the Iowa Medical Society representative on the Medical Assistance Advisory Council (Title XIX) is to be commended for his comprehensive report on matters relating to the Title XIX program. The report reiterates the concern of physicians as to regulations instituted by governmental departments in an apparent effort to conserve Medicaid

funds. The Subcommittee on Public Assistance finds itself increasingly less effective in dealing with matters relating to Title XIX as federal regulations and legislative bodies take over what was formerly a Departmental function. The Reference Committee recommends that every member of the House carefully read the report from Dr. O'Brien in order to become more familiar with present activity in the Title XIX program.

Mr. Speaker, I move the adoption of this portion of the report.

The Report comments on a requirement that all physician payments under Title XIX be reported to Internal Revenue Service. The 1969 Internal Revenue Form 1099 to physicians from Blue Shield listed one total amount for payments made by Blue Shield and Medicare. Another form was sent out for Medicaid. This resulted in some confusion at the physicians' offices and difficulty interpreting the Form. The Reference Committee recommends that in 1970 Blue Shield provide a breakdown of payments under the various programs when it reports to Internal Revenue and physicians.

Mr. Speaker, I move the adoption of this portion of the report, as amended.

SUPPLEMENTAL REPORT OF THE STATE CLAIMS REVIEW COMMITTEE

The Reference Committee acknowledges the excellent work of the State Claims Review Committee during the past year in adjudicating problem cases. As stated in the Supplemental Report, there is still much misunderstanding among physicians as to the rigidity of federal regulations regarding the determination of a reasonable charge and the interpretation of guidelines pertaining to payment for "custodial care vs medical care." The Committee believes that as the District Peer Review Committees become more active the number of cases reviewed by the State Claims Review Committee will be reduced.

Mr. Speaker, I move the adoption of this portion of the report.

Last year this House of Delegates endorsed the creation of a special committee on payment for surgery and surgical assistants under Medicare. The Supplemental Report of the State Claims Review Committee details the findings of that special committee. The study results point up the need for more complete and accurate information on claims involving surgery which could permit the Carrier to determine what payment should be made to each physician involved in the case. The Reference Committee notes that there was no debate on the report during the opening hearing. The recommendations of the Committee are as follows:

"The Committee recommends that in the future all claims submitted by physicians should indicate which of the five components of a surgical illness are represented by the charge listed on the claim form. Such itemization will result in a more equitable administration of third party programs, particularly Blue Shield, Medicare and Medicaid.

Five Components of a Surgical Illness

1. The patient workup.
2. Normal pre-operative care.
3. Surgery.
4. Surgical Assistant.
5. Normal post-operative care.

"To implement this recommendation the Committee feels that an educational program should be undertaken by the Iowa Medical Society and Blue Shield. Such an educational program should involve all physicians but perhaps with special emphasis on physicians practicing family medicine or a surgical specialty.

"The Committee believes that nothing in this recommendation will require a change in the long established policy of the Iowa Medical Society with regard to payment for surgery and surgical assistants. *However, if the recommended* program is to succeed, *great attention will need to be devoted to the completion of claims by physicians.*

"The Committee recognizes that close liaison will be required between the Iowa Medical Society and the Carrier to assure physicians that the Carrier has methods to properly identify and code claims for surgery. Only with this assurance could the program be favorably received."

The Reference Committee recommends adoption of these Committee suggestions.

Mr. Speaker, I move the adoption of this portion of the report.

(That portion of the Reference Committee report beginning with the paragraph, "Last year the House of Delegates . . .," was referred for further study to the State Claims Review Committee by a 49 to 32 vote.)

The final portion of the Supplemental Report of the State Claims Review Committee involves the establishment of "standards of medical care." The Reference Committee agrees that as third party programs become more deeply involved in the financing of medical care physicians must insist that any guideline or standard adopted by third parties for the processing and paying of claims be established in consultation with the medical profession. Several county and state societies have recently undertaken active programs to determine what "standards of medical care" are generally acknowledged as acceptable by physicians in that area. The Reference Committee sees a need for activity by the Iowa Medical Society in this area. If the peer review program is to function efficiently and in the best interest of all parties, acceptable guidelines are required. The Reference Committee, therefore, recommends that the Society assign to an appropriate committee the responsibility for formulating "standards of medical care," which can be made available to the physicians of Iowa and responsible peer review committees. This committee should establish a working relationship with the Blue Shield Quality Assurance Department to offer its expertise on a continuing basis.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 4—INTRODUCED BY THE WOODBURY COUNTY MEDICAL SOCIETY MEDICARE EXPLANATION OF BENEFITS FORM

Federal regulations do not permit the physician to receive a copy of the Medicare Explanation of Benefits Form in cases where he has not accepted an assignment. The Reference Committee agrees that it will assist the physician in properly serving his patient if he has the benefit of knowing how Medicare has handled the patient's claim for payment. The Reference Committee recommends adoption of Resolution No. 4 rec-

ognizing that it requires a change in federal regulations before it can be implemented.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 6—INTRODUCED BY THE PAGE COUNTY MEDICAL SOCIETY SPONSORSHIP OF BLUE SHIELD

This House of Delegates has often reaffirmed its support of Blue Shield. It is apparent that many problems do exist between individual physicians and Blue Shield. However, the Reference Committee believes these problems basically relate to a lack of adequate communication, particularly as it pertains to Blue Shield's role as Carrier for Medicare and Medicaid in contrast to its role as a private program. Blue Shield, as the largest health care third party payment organization in Iowa, still is the only mechanism through which the physician has an effective voice in establishing programs which physicians feel are in the best interest of their patients. The Reference Committee, therefore, recommends that Resolution No. 6 be rejected and that the Iowa Medical Society reaffirm its support of Iowa Blue Shield.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 7—INTRODUCED BY THE WAYNE COUNTY MEDICAL SOCIETY TITLE XIX BILLING

This resolution requests that physicians bill for services rendered Title XIX recipients in the same fashion as they bill other patients. The Iowa Medical Society has long supported the concept of uniform insurance reporting forms. The Committee is aware that the Title XIX billing form is prescribed by the Department of Social Services and is similar to the Medicare billing form. The Reference Committee would recommend adoption of a substitute resolution in lieu of Resolution No. 7:

Resolved, That the Iowa Medical Society encourage all third parties, be they governmental or private, to work toward the use of standard insurance reporting form for physicians' services.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 10—INTRODUCED BY THE SCOTT COUNTY MEDICAL SOCIETY MEDICAID PILOT PROGRAM

The Reference Committee was informed that various Iowa governmental agencies are considering the possibility of underwriting the Medicaid program on a pre-payment or insurance basis. The concept of covering Medicaid recipients through private programs has long been supported by the Iowa Medical Society. The Reference Committee, therefore, recommends adoption of Resolution No. 10.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 13—INTRODUCED BY THE DUBUQUE COUNTY MEDICAL SOCIETY "MINIMUM STANDARDS" FOR "HEALTH INSURANCE"

The American Medical Association many years ago undertook a program to approve health insurance contracts if they met certain standards. This program was later abandoned by the AMA. The difficulty of determining which contracts should be approved and which contracts did not meet the standards presented insurmountable administrative problems. The Iowa Medical Society has encouraged all underwriters of health insurance to offer programs of a comprehensive nature. This concept is still supported by organized medicine. The Reference Committee recommends that Resolution No. 13 not be adopted.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 17—INTRODUCED BY THE DES MOINES COUNTY MEDICAL SOCIETY BLUE SHIELD CONTRACT

The Reference Committee finds the resolution unclear and not specific as to the exact intent. No delegate was present to clarify the resolution, so the Reference Committee recommends that the resolution not be adopted.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 18—INTRODUCED BY THE WEBSTER COUNTY MEDICAL SOCIETY MEDICARE REASONABLE CHARGES

The Reference Committee is informed that the Medicare Carrier has already contacted federal officials to determine if a phrase other than "more than the allowable charge" could be used by the Carrier in its explanatory material. The Reference Committee was told that the federal government stipulates exactly what phrases and words can be used on Medicare forms. The Reference Committee feels a more acceptable method of informing a patient that a physician's charge is being reduced might be helpful but this will not solve the problem of communications between the Carrier, the patient and the physician. Even in view of these reservations, the Reference Committee recommends adoption of Resolution No. 18.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 19—INTRODUCED BY THE BOONE COUNTY MEDICAL SOCIETY MEDICARE PREVAILING FEE DISTRICTS

The Reference Committee is aware that Medicare geographical districts for the determination of prevailing charges were established in consultation with the Iowa Medical Society on a basis which placed, to the extent feasible, the same number of physicians in each particular area. Although the districts do not correspond in all respects to Iowa Congressional districts, this was the starting point for determining the present Medicare prevailing fee districts. Testimony before the Committee makes it clear that a study of the existing districts should be conducted in the interest of all parties. The Reference Committee understands that any change in the Medicare prevailing fee districts will need to be approved by HEW. The Reference Committee recommends that Resolution No. 19 be adopted.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 24—INTRODUCED BY THE POLK COUNTY MEDICAL SOCIETY PILOT SATELLITE DIAGNOSTIC AND TREATMENT CENTERS

The Reference Committee agrees with the concepts contained in Resolution No. 24. It is apparent that

physicians will continue to rely more heavily on para-medical personnel in rendering medical care. All physicians should understand that pitfalls are involved in the increased utilization of para-medical personnel, but the Committee feels these types of programs have merit. The Society has appointed an ad hoc committee to consider the establishment of a pilot project for providing certain health services in a rural area of Iowa. The Reference Committee recommends that Resolution No. 24 be referred to this special ad hoc committee for consideration and report to the Executive Council of the Iowa Medical Society.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 25—INTRODUCED BY THE WRIGHT COUNTY MEDICAL SOCIETY
MEDICARE FEES

The Reference Committee feels its recommendations on previous resolutions speak to the resolved portions of Resolution No. 25 relating to sponsorship of Blue Shield and relationships between the Iowa Medical Society, Medicare and Medicaid. We, therefore, recommend that Resolution No. 25 not be adopted.

Mr. Speaker, I move the adoption of this portion of the report.

RESOLUTION NO. 26—INTRODUCED BY THE POCAHONTAS COUNTY MEDICAL SOCIETY
BLUE SHIELD COMMUNICATIONS

The open hearings make it crystal clear that one of the basic problems affecting individual physicians' reactions to Medicare, Medicaid and Blue Shield involve communications. The frustrations voiced by physicians on unanswered letters, incorrect payments, requests for refunds and similar problems are too general to classify them as isolated instances. These matters deserve immediate attention by all involved parties. Blue Shield has a Physician Information Department to handle inquiries from physicians involving Blue Shield, Medicare and Medicaid. Many other programs exist in an attempt to inform physicians regarding these programs and to clarify interpretations of rules and regulations. The Committee is well aware of the excellent liaison which has been established between officers of Blue Shield and officers of the Iowa Medical Society. This same liaison exists at the top executive level. These avenues of communication should be maintained and strengthened. Physicians who serve on the Blue Shield Board should be commended for their efforts on behalf of Iowa doctors.

The Reference Committee believes the problem may rest in large measure on an apparent weakness relating to day to day communications between Blue Shield and physicians on the details of claim completion and claim payment. The Reference Committee fully appreciates the difficulties presented to Blue Shield by the maze of federal regulations and the constant change in these regulations which hamper efforts by Blue Shield to refine its communications mechanisms with individual physicians. It is not the task of this Reference Committee to suggest specific programs to alleviate this problem. Ideas such as an incoming WATS line that physicians could use to contact Blue Shield and specific individuals to be contacted on Medicare, Medicaid and Blue Shield problems were mentioned. The Reference Committee hopes the recent change in computer processing of claims may in the long run accrue to the benefit of Blue Shield and physicians by reducing the payment cycle time and the number of claim errors. The Reference Committee recommends that the Iowa Medical Society and Blue Shield undertake at all levels a program to reduce the seemingly minor irritations involving claim processing and payment since these minor irritations have now to many physicians magnified into major proportions. The Reference Committee recommends the adoption of the following substitute resolution in lieu of Resolution No. 26:

Resolved, That changes be considered in the administration of Title XIX and Medicare to correct and alleviate administrative errors; and be it further

Resolved, That the names and telephone numbers of individuals assigned to aid in answering questions, either in writing or by phone for Title XIX and Medicare, be widely disseminated to Iowa physicians.

Mr. Speaker, I move the adoption of this portion of the report.

In closing the Reference Committee reminds members of the House that the problems presently facing physicians are vast in impact with probable long-range effect on the delivery of medical care. Society officers are called upon daily to make judgments based on actions of the policy-making body of the Iowa Medical Society, this House of Delegates. This is obviously not an easy task. All physicians owe a special vote of thanks to those individuals who devote their energy and take time from the active practice of medicine to foster the interests of all Iowa physicians. These are trying times for all citizens and particularly for physicians. The Reference Committee wishes to commend the Board of Trustees for its untiring efforts on behalf of Iowa physicians as it attempts to assure physicians that all steps possible are being taken to preserve the physician-patient relationship in the interest of good health care for all Iowa citizens.

Mr. Speaker, I move the adoption of this portion of the report.

Mr. Speaker, I move the adoption of this report as a whole, as amended.

Respectfully submitted,
D. F. RODAWIG, JR., M.D., *Chairman*
J. M. TIERNEY, M.D.
M. R. SAUNDERS, M.D.
D. E. CONKLIN, M.D.
L. J. FLAGE, M.D.

The Speaker then asked whether there was any new business to come before the House. Dr. Schlaser made a motion that the House of Delegates approve the actions of the IMS Board of Trustees from the date of the last previous annual meeting. The motion, which was worded as follows, was seconded and adopted:

Resolved, That the actions of the Board of Trustees of the Iowa Medical Society from the date of the last annual meeting to the present be and hereby are ratified and confirmed.

Dr. Schlaser then continued: "Mr. Speaker, I have the pleasant task of offering another motion to the House of Delegates. One could introduce this motion by a lengthy laudatory statement but I simply want to say personally, and on behalf of the other officers of the Society, how much we have enjoyed working with our President, Dr. Bob Krigsten. I am sure this opinion is shared by the House of Delegates as already has been expressed."

Dr. Schlaser offered a resolution that the 1972 an-

nual meeting of the Iowa Medical Society be held in Des Moines on April 23-26. It was adopted.

Dr. Caraway expressed the thanks of the delegates for the Medical Assistants Association's serving coffee at the Sunday morning meeting. He also expressed special thanks to Mr. Don Taylor, executive vice-president, and his fine staff.

The Speaker then announced that the organizational meeting of the Board of Trustees would be held immediately following the adjournment of the House of Delegates, and that the organizational meeting of the Judicial Council would occur at that time too. He also reminded the delegates that the installation of the new president of the IMS would occur following the formal adjournment and prior to those other two meetings.

The meeting was adjourned at approximately 1:00 p.m.

Fifty Year Club Members

June 1, 1970

Ash, William E. Council Bluff

Banton, Oscar H. Charles City
Bartlett, George E. New Sharon
Bessmer, William C. Sun City, Arizona
Billingsley, John W. Newton
Blaha, George A. Whitten
Block, Charles E. Davenport
Bowie, Louis L. Zearing
Braunlich, George Davenport
Brereton, Harold L. Emmetsburg
Brinkman, William F. Pocahontas
Broderick, Clarence E. Cherokee
Bullock, William E. Lake Park
Burke, Thomas A. Mason City

Carstensen, Albert B. Linn Grove
Christensen, John R. Menlo Park, California
Clapsaddle, John G. Burt
Closson, Charles L. Walker
Commey, Roy M. Tujunga, California
Cooper, Gladys A. Lansing, Michigan
Crawford, Robert H. Burlington
Cretzmeyer, Francis X. Emmetsburg
Crew, Arthur E. Marion
Crow, George B. Burlington
Cusick, George W. Davenport

Dahl, Harry W. Des Moines
Dahlbo, John E. Sutherland
Doane, Grace O. Des Moines
Downing, Leroy M. Cedar Rapids
Dyson, James E. Phoenix, Arizona

Egermayer, George W. Elliott
Eggleston, Alfred A. Burlington

Feightner, Robert L. Fort Madison
Felter, Allan G. Van Meter
Fillenwarth, Floyd H. Charles City
Foster, Warren H. Clinton
Foster, Wayne J. Cedar Rapids
Franchere, Chetwynd M. Mason City
Frank, Owen L. Maquoketa

Gernsey, Merritt Long Beach, California
Gibson, Paul E. Des Moines
Goggin, John G. Ossian
Gottsch, Erwin J. Shenandoah
Gutch, Roy C. Knoxville, Tennessee

Hamilton, Benjamin F. Jefferson
Harken, Conreid R. Osceloa
Harris, Ray R. Dubuque
Henkin, John H. Sioux City
Herrmann, Christian H. Middle
Hill, Julia Ford Grinnell
Hill, Lee Forrest Des Moines
Hopkins, David H. Des Moines
Hornaday, William R., Sr. Des Moines

Jerdee, Ingebrecht C. Clermont
Johann, Albert E. Des Moines

Kershner, Frank O. Clinton
Kimball, John E. West Liberty
Kleinberg, Henry E. Des Moines
Knight, Benjamin L. Cedar Rapids

Loving, Luther W. Estherville

McBride, Robert H. Sioux City
McCoy, Harold J. Des Moines
McCreight, George C. Carmel Valley, California
McHugh, Charles P. Ft. Lauderdale, Florida
Maplethorpe, Charles W., Sr. Toledo
Marker, John I. Davenport
Marquis, George S. Des Moines
Maxwell, Charles T. Sioux City
Maxwell, John, Sr. What Cheer
Mellen, Robert G. Clinton
Meyers, Frank W. Dubuque
Mitchell, Claire H. Cincinnati
Moershel, Henry G. Homestead
Mooney, James C. Des Moines
Murray, Frederick G. Des Moines

Neal, Emma J. Cedar Rapids
Neuzil, William J. Cedar Rapids

O'Brien, Stephen A. Mason City

Paige, Ralph T. La Porte City
Palmer, Carson W. Guttenberg
Pearson, George J. Burlington
Peasley, Harold R. Des Moines
Peterson, Frank R. Cedar Rapids

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(Continued on page 542)

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INDEX

Abortion, 462, 463, 497, 506, 521ff.
Accident and Sickness Disability Income, group program, 469
Aging and Chronic Illness, Subcommittee on, 460
Alcoholism, proposed IMS committee on, 463
Ambulance Services, 465
Annual Meeting Program, 1970, 450
Articles of Incorporation and By-Laws, Report of Reference Committee on, 516ff.
Articles of Incorporation and By-Laws, Standing Committee on, 454
Articles of Incorporation and By-Laws, Supplemental Report of Committee on, 494, 516ff.
Attendance, 449, 515

Black Hawk County resolution, SAMA membership in IMS, 510-511, 519
Blood Banking, Committee on, 466
Blue Cross-Blue Shield Statewide Physicians Group Program, 468
Blue Shield, Board of Trustees, Supplemental Report, 484
Blue Shield, discussion of mental health coverage, 463
Blue Shield, quality assurance program (QAP), 464, 486, 500, 526
Blue Shield, relations with, 457, 509, 529
Blue Shield, Report by Chairman, Board of Directors, 484ff., 526-527
Blue Shield, Report by President, 486ff., 526-527
Board of Trustees, Supplemental Report, Section I, General Activities, 479ff., 524
Board of Trustees, Supplemental Report, Section II, Medicare-Medicaid-Peer Review, 482ff., 525-526
Board of Trustees, Supplemental Report, Section III, Blue Shield, 484ff., 526-527
Board of Trustees, Supplemental Report, Section IV, Finances, 487-488, 524-525
Board of Trustees, Supplemental Report, Section V, Foundation for Medical Care, 488-489, 525
Boone County resolution, Medicare prevailing districts, 513, 529

Chiropractic, 474, 512-513, 520
Civilian Health and Medical Program of Uniformed Services (CHAMPUS), 457
Clinton County resolution, abortion, 506, 521-522
College of Medicine, relations with, 481
Committee on Articles of Incorporation and By-Laws, Supplemental Report of, 494ff., 516ff.
Commitment laws, 463
Comprehensive health planning, 471
Continuing medical education, U. of I. program, 456
Councilor districts, creation of new, 454, 494, 509, 517
County Society Officers, 532

Dallas-Guthrie County resolution, councilor districts, 509, 517
Delivery of Health Service to Rural Area in Need, ad hoc committee on, 466
Des Moines and Louisa County resolution, hyphenation, 513, 525
Des Moines County resolution, Blue Shield Medicare carrier contract, 513, 529
Dialysis, 472
Disaster planning, 472
"Doctor's House Call" radio series, 459
Drug abuse conference, 458-459
Dubuque County resolution, malpractice, 512, 521
Dubuque County resolution, minimum standards for health insurance, 512, 529

Eckstein, John W., M.D., 490
Economics of Health Care, Committee on, 466
Employment of Handicapped, Committee on, 466-467
Executive Council, 450, 510, 516
Extended Care Facilities, guidelines covering, 482
Eye Care, Committee on, 468

Family Practice, Department of, 490-491
Family Practice, U. of I. Department of, 456, 474, 490-491
Fifty Year Club, 531
First aid, 502
Foundation for Medical Care, 488

Grievance Committee, 455
Group Insurance, Committee on, 468

Hall of Health, Iowa State Fair, 459
HANDBOOK FOR 1970 HOUSE OF DELEGATES, reports from, 450ff.
Hardin, Robert C., M.D., 489-490
Hawkeye Science Fair, 459
Health care costs, 466
Health Education, Committee on, 455
Health Planning Council of Iowa, 471
Hearing screening, 468
Himler report, Report of Reference Committee on, 523-524
Historical Committee, 469

Home Health Services, Subcommittee on, 457

Immunization, Rubella program, 460, 462
Independent Laboratories, Committee on, 469-470
Industrial Health, Committee on, 470
Insurance and Medical Service, Report of Reference Committee on, 525ff.
Interprofessional Activities, Subcommittee on, 459
"In the Public Interest" feature in JOURNAL, 459
Iowa Bar Liaison Committee, 470
Iowa commissioner of health, 460
Iowa Health Council, 458, 459, 474
Iowa Medical Assistance Program, 463-464
Iowa Nursing Home Association, 460
Iowa Optometric Association, 468, 473
Iowa Pharmaceutical Association, liaison with, 459
Iowa Regional Medical Program and Comprehensive Health Planning, Committee on, 471
Iowa Security Medical Facility, 463
Iowa Society of Medical Technologists, 470

JOURNAL OF IOWA MEDICAL SOCIETY, 465
Judicial Council, 450, 453-454
Judicial Council, Report of Reference Committee on, 525

Kidney transplantation, 472

Laboratory Advisory Committee, 470
Legislation and Miscellaneous Business, Report of Reference Committee on, 519ff.
Legislation and Miscellaneous Business, Report of Reference Committee on, Minority Report-Section on Abortion, 522-523
Legislation, Committee on, 456
Legislation, Supplemental Report of Committee on, 496-497, 519ff.
Life and Associate Memberships, 515
Life insurance, group program, 469

MacQueen, John C., M.D., 490-491
Malpractice, coverage for physicians, 458, 470-471
Marion County resolution about vexatious litigation, 506, 521
Maternal and Child Health, Subcommittee on, 460
Maternal and Child Health, Supplemental Report of Subcommittee on, 497-499, 521ff.
Medicaid, 463-464, 482ff., 496, 500ff., 525-526, 527-528
Medical Assistants Advisory Committee, 471
Medical Education and Hospitals, Committee on, 456
Medical Examiner Law, Subcommittee on, 456
Medical manpower, Conferences on, 458, 475
Medical Manpower, Task Force on, 457, 458, 474, 475
Medical Practice in Hospitals and Nursing Homes, Subcommittee on, 458
Medical Service, Committee on, 457
Medical Student Membership in IMS, ad hoc committee on, 471
Medicare, 482ff., 496, 504, 525-526
Medicare, freeze on fees, 482
Medicare services covered in extended care facilities and skilled nursing homes, 482
Medicine and Religion, Committee on, 471
Medico-Legal Committee, 458
Membership in IMS for medical students, 471, 495.
Membership for qualified osteopaths, 494-495
Membership in IMS of qualified osteopaths, 454, 473, 494-495
Memberships, AMA, 452
Memberships, IMS, 451-452, 453-454
Medicare, statements re: excessive costs, 482
Mental Health programs, legislative proposals, 463
Mental health-retardation services, State Department of Social Services, 462

National Emergency Medical Service, Committee on, 472
Necrology Committee, 455-456, 494
Nominating Committee, Supplemental Report of, 493
Nursing home administrators, licensure of, 458
Nursing homes, proposed legislative standards, 458, 460
Nutrition Council of Iowa, 474

Officers, Iowa Medical Society, 533
Oncology, Committee on, 472
Oncology, Supplemental Report of Committee on, 503, 520
Opticians' registration, 468, 473
Organ Transplantation, Committee on, 472
Osteopathic and MD/DO Liaison Committees, 472-473
Osteopathic evaluation and enrollment program, 454, 472-473
Osteopathic physicians, IMS membership for, 454, 473

Page County resolution, Blue Shield sponsorship, 509, 529
Paramedical Service, Committee, 473-474
Peer Review, 457, 463, 464, 467, 483, 486, 488, 500, 525
Plymouth County resolution, medical tape library, 514, 520
Pocahontas County resolution, Blue Cross/Blue Shield relations, 515, 530
Podiatrists, prescribing of drugs by, 459
Polk County resolution, architectural education committee, 514, 521
Polk County resolution, distribution of delegates, 510, 517
Polk County resolution, emergency care services, 514, 521
Polk County resolution, pilot satellite diagnostic and treatment centers, 514, 529-530
Pottawattamie-Mills County Society, hyphenation of, 454
Preceptorship Committee, 474
Prescription drugs, right of nurses to dispense under supervision, 459
Professional corporations, 469, 470, 496
Professional corporations, 496
Professional liability, 458, 470-471
Psychiatric Care, Subcommittee on, 462
Publications Committee, 465
Public Assistance, Subcommittee on, 463ff.
Public Assistance, Supplemental Report of Subcommittee on, 500, 527-528
Public health, commissioner of, 460
Public Relations Committee, 458

Quackery, Committee on, 474

Red measles, mass immunization programs, 462
Rehabilitation, Subcommittee on, 465
Renal dialysis and transplantation, 472
Reports of Officers, HANDBOOK, 450ff.
Reports of Officers, Report of Reference Committee on, 524ff.
Reports of Standing Committees, HANDBOOK, 454ff.
Rubella eradication program, 497
Rubella immunization, statewide program, 460, 462, 497
Rural Health, Committee on, 475

Safe Transportation, Subcommittee on, 465
Safe Transportation, Supplemental Report of Subcommittee on, 502, 521
Scanlon Medical Foundation/Iowa Medical Society, Report of, 491ff.
Scott County resolution, abortion, 506, 521-522
Scott County resolution, Executive Council membership, 510, 516
Scott County resolution, Himler report, 513, 523-524
Scott County resolution, Medicaid pilot program, 510, 529
Secretary, from office of, 450
Sex education in schools, 455
Shelby County resolution, chiropractic, 512-513, 520
Sioux County resolution, Himler report, 509, 523
Skilled Nursing Homes, guidelines covering, 482
Special Committees, Reports of, 466
Special Committees, Supplemental Reports of, 503ff.
Sports Medicine, Committee on, 475, 520
Standards of Medical Care, 505
Standing Committees, HANDBOOK, Reports of, 454ff.
Standing Committees, membership, 533
Standing Committees, Supplemental Reports of, 493ff.
Special Committees, membership, 535
State Board of Health, physicians representatives, 460
State Claims Review Committee, 475
State Claims Review Committee, Supplemental Report, 503, 528
State Commissioner of Health, 460
State crime laboratory, 497
State Department of Health, laboratory advisory committee, 470
State Department of Health, rubella and red measles programs, 462
State Department of Social Services, Medicaid actions, 464
State Departments, Committee on, 460
State medical examiner, 456
Supplemental Reports, 479
Surgery and surgical assistants, payment under Medicare, 504-505

Task Force on Medical Manpower, 457, 458, 474, 475
Title XIX advisory council, 464, 500ff.
Title XIX implementation, 463-464, 500ff.
Treasurer, Report of, 452-453

Uniform Anatomical Gifts Act, 466
Usual and customary fee concept, 466-467
Usual, customary and reasonable fee concept (Blue Shield UCR Program), 485, 526

Voluntary Health Agencies, Committee on, 478-479
Voluntary Health Agencies, Supplemental Report of Committee on, 505, 521

Wayne County resolution, Title XIX billing, 509, 529
Webster County resolution, Medicare reasonable charges, 513, 529
Woman's Auxiliary Advisory Committee, 479
Woodbury County resolution, Medicare forms, 509, 528-529
Workmen's compensation, 470
Wrestling, high school weight determination, 475
Wright County resolution, government fee fixing, 514-515, 530

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Index to Advertisers

American Tobacco Institute 476-477

Arch Laboratories 541

Becton, Dickinson and Company 486A, B

Burroughs-Wellcome & Co. 510B

Campbell Soup Company 490A

Casualty Indemnity Exchange 543

Conal Pharmaceuticals, Inc. 490D

Dow Chemical Company 510A

Geigy Pharmaceuticals 510D, 511

Hynson, Westcott & Dunning, Inc. 439

Lederle Laboratories 438, 441, 498

Lilly, Eli, & Company 437, 442

Medical Protective Company 501

National Drug Company 470A, B, 526A, B

National Safety Council 500

Poythress, Wm. P., & Company 510C

Prouty Company 447

Roche Laboratories 544

Searle, G. D., & Company 490B-C

Seven-Up Bottlers of Iowa 542

Schering Laboratories 454A, B, C, D

Stuart Pharmaceuticals, Div. of Atlas Chemical Industries, Inc. 461

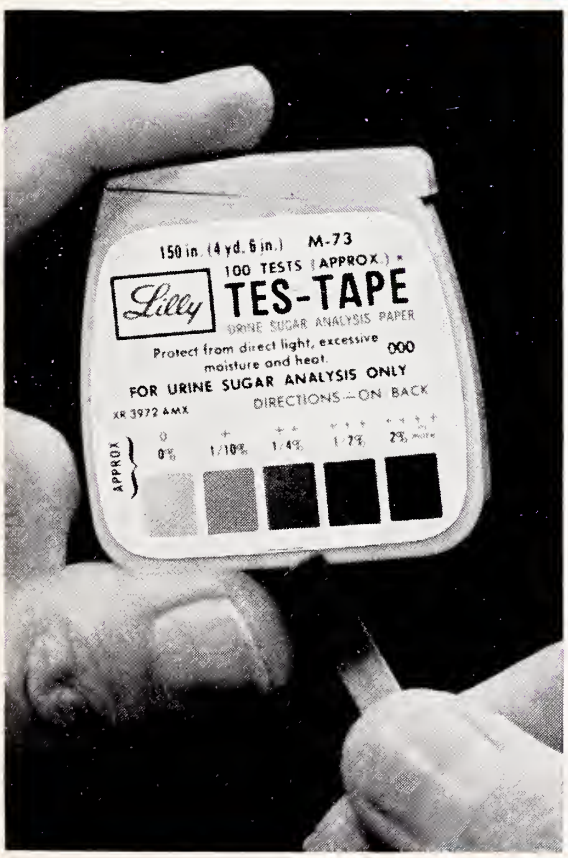
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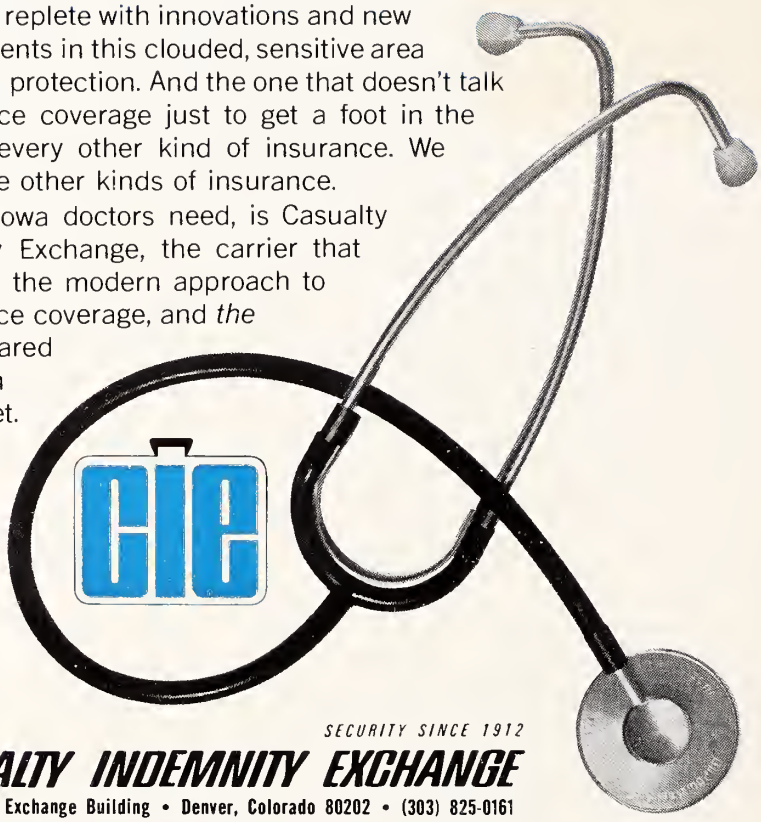
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The JOURNAL of THE IOWA MEDICAL SOCIETY

Vol. LX AUGUST, 1970 No. 8

CONTENTS

SCIENTIFIC ARTICLES

Evaluation and Treatment of Respiratory Allergy in Iowa
Hal B. Richerson, M.D., Paul M. Seebohm, M.D., and J. Montgomery Smith, M.D. 559

Community Hospital Experience With Emergency Cardiac Resuscitation
L. W. Swanson, M.D. 569

Diagnosis and Management of a Prepartum Female With Acute Symptoms of Hypertension and Uremia
Kennedy C. Fawcett, M.D., John Sibley, M.D., and David Wall, M.D. 570

EDITORIALS

Successful Rubella Efforts 577
The Highway Carnage 577
On the Positive Side 578
Profitable Programs for Youth 579
Views on Anticoagulant Therapy 580
A Husband's Responsibility 581
Use Caution in Sunbathing 581

SPECIAL DEPARTMENTS

Coming Meetings 552
Month in Washington 555
President's Page 582
In the Public Interest facing page 582
University Hospitals Drug Letter: Anti-Anxiety Agents
Richard Finn, M.D. 583
Information from Iowa Heart Association: Treatment of Hypertension
Harriett P. Dustan, M.D. 585
Doctor's Business 587
Iowa Association of Medical Assistants 588
State Department of Health 590
Woman's Auxiliary News 594
Personals 597
Deaths 601

MISCELLANEOUS

U. of I. Continuing Education Courses and Conferences 552
U. of I. Urology Postgraduate Conference . . . 553
Conference on Pediatrics 557
Survey on Small Community Practice 557

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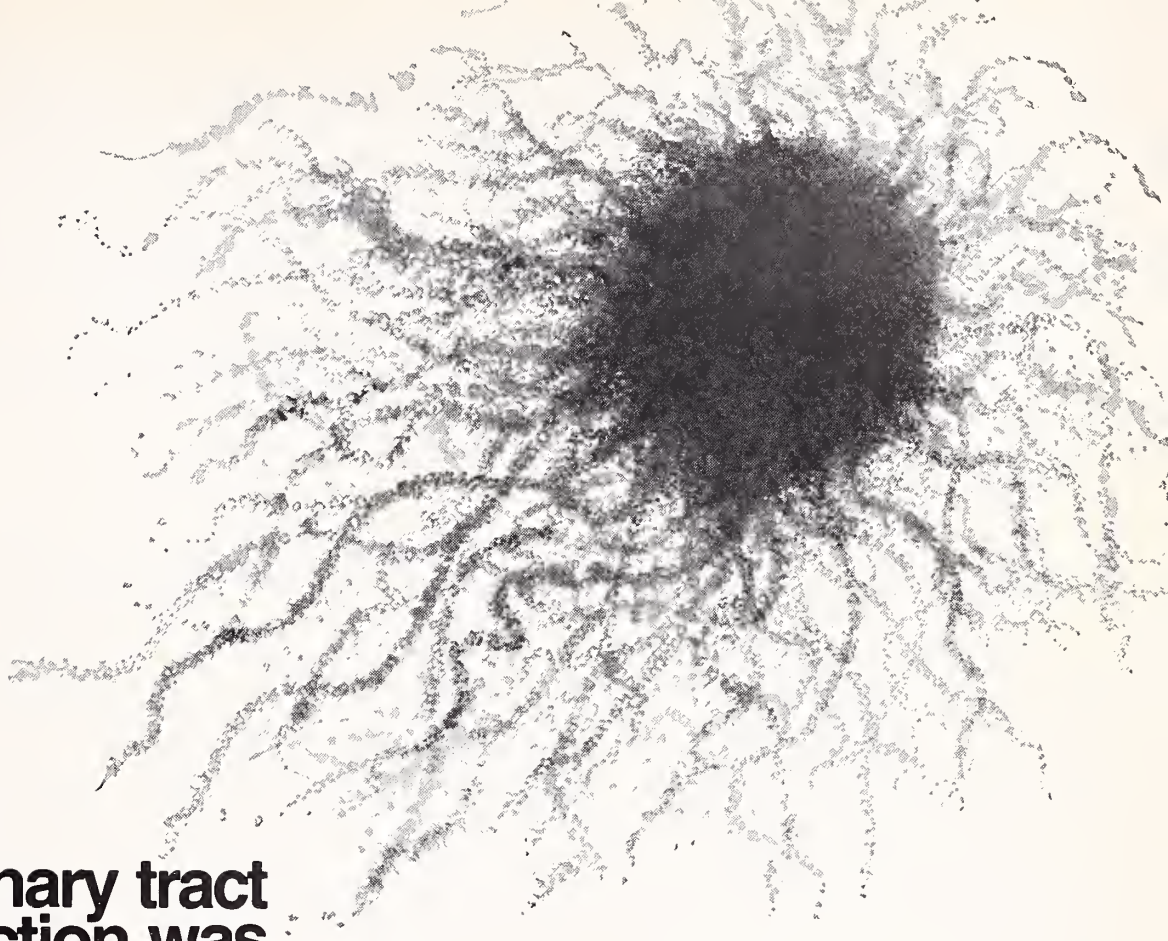
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The Tobacco Institute believes the American public is entitled to complete, authenticated information about cigarette smoking and health.

The American Cancer Society does not seem to agree

Is the public entitled to complete, authenticated information about research on cigarette smoking and health? The Tobacco Institute thinks it is; the American Cancer Society apparently thinks it is not.

The Tobacco Institute has recently challenged the Cancer Society on a matter of importance to the public—and the public health. The Cancer Society has not accepted this challenge.

On February 5, the Cancer Society called a press conference in the Waldorf-Astoria Hotel in New York City to discuss a research project titled, "The Effects of Cigarette Smoking Upon Dogs." Through the efforts of the Cancer Society, the public was led to believe that this experiment is a landmark achievement which, for the first time, demonstrates that lung cancer, resembling lung cancer in humans, can be produced in animals with cigarette smoke.

The Cancer Society claimed that this result refutes the contention of the tobacco industry that there is no laboratory proof of a connection between cigarette smoking and lung cancer. The Society also said that the findings should have an impact on cigarettte smoking and should result in a reassessment of the advertising claims and policies of the tobacco industry.

The Tobacco Institute does not —and the public should not—accept these claims at face value. Here are the reasons:

1. The present accounts of this study are based solely upon information and interpretations provided to the press. The study has not been published in any scientific journal. The findings were not subjected, as such findings normally are, to rigorous independent scientific review.

2. This history of tobacco and health research contains many examples of experiments which were initially hailed as scientific breakthroughs, but on later evaluation proved to be of little significance. Unfortunately, the initial and premature announcement of these experiments makes news, but the later criticism of the work rarely comes to public attention.

3. The Tobacco Institute has requested the Cancer Society, in writing, to permit a thorough independent evaluation of the experiment and its results. We said we would propose as reviewers men of outstanding competence and integrity, with wide experience in areas relevant to the data, who, we believed, would be thoroughly acceptable to the Society. We also state that if the Society should, for goo reason, reject any scientist we pro pose, we would nominate a substi tute. Finally, we offered to bear al costs needed for this independen analysis.

The Cancer Society has twice re jected this proposal—in letters date March 12 and April 17.

We continue to hope that th American Cancer Society will per mit the examination of this work i the manner we have proposed. I the study is as important as the Can cer Society has represented it to be the Society should have no hesita tion in submitting if for review.

The tobacco industry recognize and accepts a responsibility to pro mote the progress of independen scientific research in the field of to bacco and health. In dischargin that responsibility, we believe tha the industry has spent, and conti nues to spend, more money for suc research than any organization i the United States.

If the Cancer Society continue to deny access to this recent work we believe this will serve as convinc ing evidence to the public, lay an scientific, that the data will not sup port the allegations made at the So ciety's Waldorf-Astoria conference

We will be pleased to send the complete text of all correspondence on this matter between the Cancer Society and The Tobacco Institute to any interested individual or group.

The Tobacco Institute

1776 K Street, N.W., Washington, D.C. 20006

FROM THE TOBACCO INSTITUTE

March 20, 1970

Mr. William B. Lewis
Chairman of the Board
The American Cancer Society
219 East 42nd Street
New York, New York 10017

Dear Mr. Lewis:

I have your letter of March 12, 1970. I am greatly disappointed that the American Cancer Society has refused to permit the impartial review of the Auerbach-Hammond data which I requested in my letter of February 27. Since the Society has called upon the cigarette industry to reassess its policies in light of the findings, it is only fair and proper for the Society to permit us to have those findings evaluated by independent experts—and immediately.

You will recall that I propose to nominate as reviewers several well-known scientists highly qualified in the fields of experimental work, tumor pathology and lung diseases. They will all be subject to your rejection for good cause.

Your reasons for denying my request, as I understand them from your letter, are that the formal papers will be published in the very near future and that a study of them will satisfy any scientific or other questions regarding the findings. I do not find these reasons for denying my request at all convincing.

First, publication in a scientific journal will not occur until many months after the Waldorf-Astoria press conference of February 5.

Second, the American Cancer Society at that press conference made serious allegations against this industry and its products. The Society said in its press release that the Auerbach-Hammond findings "should have a significant impact on the smoking of cigarettes in this country, and will probably lead to a reassessment of advertising claims and policies of the cigarette industry." These findings have been widely publicized in newspapers and the medical press. How can the Cancer Society say that serious analysis of the work must be delayed until formal publication!

Finally, the published papers cannot satisfy questions about such matters as the proper interpretation of the pathologic material, the allegation that cigarette smoke produced various effects in the dogs, the validity and adequacy of the experimental design and procedure, and in general whether, as you assert. the experiment "meets the highest traditions and protocol of scientific investigation." These matters can only be resolved by examination of the pertinent data and material.

If the Cancer Society does not accede to my request, we plan to use every means at our disposal to see to it that the medical and lay public are made aware of our respective positions in this matter. Furthermore, we intend to continue to press our request for exposure of this experiment to impartial scientific scrutiny by qualified experts in the manner suggested. If the Cancer Society continues to deny access to the work, I believe this will serve as convincing evidence to the public, lay and scientific, that the Auerbach-Hammond data will not support the allegations made at the Society's Waldorf-Astoria conference.

Yours very truly,

Joseph F. Cullman, 3rd
Chairman of the Executive Committee,
The Tobacco Institute, Inc.

FROM THE AMERICAN CANCER SOCIETY

April 17, 1970

Mr. Joseph F. Cullman, III
Chairman of the Executive Committee
The Tobacco Institute, Inc.
Philip Morris, Inc.
100 Park Avenue
New York, New York 10017

Dear Mr. Cullman:

The Veterans Administration, the American Cancer Society and Doctors Auerbach and Hammond cannot accede to the requests stated in your letter of February 27 and March 20 for an evaluation of the Auerbach-Hammond study on "The Effects of Cigarette Smoking Upon Dogs" by a panel of independent scientists chosen by you.

Your request is without precedent in the scientific community. The study under question was the result of three and a half years of diligent and brilliant work by two eminently qualified scientists whose findings have been validated by distinguished pathologists of worldwide reputation. In addition, other leading pathologists, highly regarded by the scientific community, have visited Dr. Auerbach's laboratory, seen his slides and praised the work.

We do not intend to ask that these two eminent men submit their findings to any selected committee chosen by the Tobacco Institute, or any other group. Their work will be judged in the traditional manner of American science, where findings are presented, discussed, accepted or rejected by scientists and physicians whose only motivation is the truth. Doctors Auerbach and Hammond worked freely and without restraint with funds furnished by the federal government and the American Cancer Society. They are beholden only to the scientific community at large and to the integrity it represents.

If the Tobacco Institute, or any scientific research group, has doubts about the findings of this study, the way it was conducted, or the credentials of the investigators, there is a time-honored and scientifically accepted way to proceed. Let your own or another group of scientists repeat the experiments in a laboratory to prove that smoking dogs will not suffer tissue damage, emphysema and lung cancer. The Auerbach-Hammond methodology is readily available to you. And I presume that in the Council for Tobacco Research you have or can set up the mechanism for conducting such a study.

If you carry out your plan to publicize "our respective positions" to the medical and lay public, you have our permission to use this letter as the position paper of the American Cancer Society.

Sincerely,

William B. Lewis

William B. Lewis

FROM THE TOBACCO INSTITUTE

April 29, 1970

Mr. William B. Lewis
Chairman of the Board
The American Cancer Society
219 East 42nd Street
New York, New York 10017

Dear Mr. Lewis:

Your letter of April 17 states that the American Cancer Society is unwilling to permit an impartial review of the Auerbach-Hammond data by "any selected committee chosen by the Tobacco Institute, or any other group."

You say our request "is without precedent in the scientific community." I submit that the Cancer Society's exploitation of this unpublished work for publicity purposes is truly without precedent in the scientific community. Through its use of publicity techniques rather than the usual scientific channels, it is the Cancer Society—not the tobacco industry—which, contrary to the traditions of American science, has projected this study into the arena of public discussion. Furthermore, in the scientific community, expert review panels are often convened to review important questions which depend upon the interpretation of research results.

You claim pathologists have visited Dr. Auerbach's laboratory, seen his slides and praised the work. Why, then, do you refuse to permit an impartial review by distinguished scientists, especially in view of your claim that this work is of great significance to the smoking public and the tobacco industry?

As you say, Doctors Auerbach and Hammond worked with funds furnished by the federal government and the American Cancer Society. Since these are funds derived from public sources, the public is entitled to a full and fair account of the results. The American Cancer Society cannot presume to be the sole custodian and interpreter of the work.

You stated that these scientists "are beholden only to the scientific community at large and to the integrity it represents." But the American Cancer Society, an organization supported by public donations, is certainly also "beholden" to its contributors and to the public at large to provide complete information about the research which it finances, especially in view of the fact that you have released news of the study to the public media. When the Society is questioned about its interpretations of such research, it should feel a responsibility to disclose the data, which, it alleges, supports its interpretations.

You suggest that the way to resolve any doubts about the study is to have another research organization repeat the work—which you say, was conducted over a period of three and a half years. This suggestion overlooks the fact that the American Cancer Society has called upon the tobacco industry to reassess its policies in light of the present findings. If this is the Society's position, it should not expect or want the cigarette industry to go through three and a half years of research to determine answers which the Cancer Society asserts are available today.

In view of the American Cancer Society's position, we are proceeding to bring this matter to the attention of the public.

Yours very truly,

Joseph F. Cullman, 3rd
Chairman of the Executive Committee,
The Tobacco Institute, Inc.

COMING MEETINGS

IN STATE

Sept. 18-19	**17th Annual Symposium on Arthritis sponsored by Section of Internal Medicine, Iowa Methodist Hospital and Iowa Chapter Arthritis Foundation,** Jester Auditorium, Iowa Methodist Hospital, Des Moines.

CONTINENTAL U. S.

Aug. 3-7	**Sixteenth Annual General Practice Review sponsored by University of Colorado School of Medicine,** Denver.
Aug. 12-15	**Fourth World Conference on General Practice,** Palmer House, Chicago.
Aug. 17-18	**Postgraduate Course on Clinical Management and Control of Tuberculosis sponsored by University of Colorado School of Medicine,** National Jewish Hospital, Denver.
Aug. 20-22	**Postgraduate Course on Hepatitis co-sponsored by American Gastroenterological Association and American Association for Study of Liver Diseases,** Snowmass-at-Aspen, Colorado.
Aug. 20-22	**Ninth National Conference on Therapies for Advanced Cancers sponsored by Division of Clinical Oncology,** University of Wisconsin Postgraduate Center, Madison.
Sept. 1-4	**Wyoming State Medical Society,** Jackson Lake Lodge, Moran.
Sept. 9-11	**Postgraduate Course on Renal Diseases: Pathophysiology, Diagnosis and Management sponsored by American College of Physicians,** Mayo Clinic, Rochester.
Sept. 10-12	**American Association of Obstetricians and Gynecologists,** Homestead, Hot Springs, Virginia.
Sept. 11-19	**American Society of Clinical Pathologists,** Marriott Motor Hotel, Atlanta.
Sept. 14-16	**Postgraduate Course on Current Practice of Clinical Electroencephalography sponsored by American Electroencephalographic Society,** Washington, D. C.
Sept. 17-19	**Annual Meeting of American Electroencephalographic Society,** Shoreham Hotel, Washington, D. C.
Sept. 18-19	**Symposium on Myocardial Infarction co-sponsored by Minnesota Heart Association and Northlands Regional Medical Program.** Methodist Hospital, St. Louis.
Sept. 19-20	**American Association of Ophthalmology,** Las Vegas.
Sept. 19-20	**Third National Congress on Medical Ethics,** Ambassador West Hotel, Chicago.
Sept. 19-25	**Annual Otolaryngologic Assembly of 1970,** University of Illinois Medical Center, Chicago.
Sept. 20-24	**Michigan State Medical Society,** Pantlind Hotel, Grand Rapids.
Sept. 21-25	**Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta.
Sept. 23	**Symposium on Surgery and Coronary Artery —An Evaluation sponsored by Adolf Gundersen Medical Foundation and Wisconsin Heart Association,** Wisconsin State University, LaCrosse.
Sept. 23-26	**Annual Meeting, Colorado Medical Society,** Broadmoor Hotel, Colorado Springs.
Sept. 24-26	**Central Association of Obstetricians and Gynecologists,** Drake Hotel, Chicago.
Sept. 25-Oct. 1	**American Academy of General Practice,** San Francisco.
Sept. 28-30	**Association of Life Insurance Medical Directors of America,** Statler Hilton Hotel, Boston.
Sept. 28-Oct. 2	**Hospital Medical Staff Conference sponsored by University of Colorado School of Medicine,** Denver.
Sept. 29-Oct. 2	**American Roentgen Ray Society,** Deauville Hotel, Miami Beach.
Sept. 30-Oct. 1	**30th Congress on Occupational Health sponsored by American Medical Association,** Century Plaza Hotel, Los Angeles.

ABROAD

August 2-8	**13th International Congress of Hematology,** Munich, Germany.
August 3-7	**11th International Congress on Diseases of Chest sponsored by American College of Chest Physicians,** Lausanne, Switzerland.
Aug. 23-28	**16th Annual Meeting of Flying Physicians Association,** Vancouver, B. C., Canada.
Aug. 28-29	**Scandinavian Neurosurgical Society, Annual Meeting,** Stockholm.
Sept. 6-12	**World Congress of Cardiology (6th),** London.
Oct. 18-Nov. 12	**Eleventh International Congress of Internal Medicine sponsored by American College of Physicians,** New Delhi.

Continuing Education Courses & Conferences

Please call or write Office of Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-4792.

Aug. 26	Refresher Course on Cerebrovascular Disease	Sept. 16	Making Nutrition a Household Word
Sept. 1 & 2	Workshop on Ophthalmologic Photography	Sept. 25 & 26	Dermatology for the Dermatologist
Sept. 9 & 10	Pediatrics Postgraduate Conference	Sept. 25 & 26	Manipulation (Physical Therapy)
Sept. 15 & 16	Urology Postgraduate Conference	Sept. 30	Refresher Course on Cerebrovascular Disease

U. of I. College of Medicine

Urology Postgraduate Conference

A Urology Postgraduate Conference will be held September 14, 15 and 16 at the Iowa Memorial Union at the University of Iowa in Iowa City. The Conference is being held in conjunction with a meeting of the Iowa Urological Society.

The Conference will commence at 6:30 p.m., Monday, September 14, with a pre-meeting reception.

Tuesday, September 15

9:00 a.m. VASECTOMY REPAIR
Dwayne E. Howard, M.D., Sioux City

9:45 a.m. OPERATIVE MANAGEMENT OF INTERSEXUALITY
Donald J. Mehan, M.D., Assistant Clinical Professor of Urology, St. Louis University, St. Louis, Mo.

10:45 a.m. FACTS & FANTASIES RE ANOMALIES OF THE MALE EXTERNAL GENITALIA
Ormond S. Culp, M.D., Chief of Section of Urology, Mayo Clinic, Rochester, Minn.

11:45 a.m. ILEAL CONDUIT—COMPLICATIONS & RESULTS
Joseph D. Schmidt, M.D.

2:00 p.m. ETIOLOGY OF BENIGN HYPERPLASIA OF THE PROSTATE
John T. Grayhack, M.D., Professor and Head, Department of Urology, Northwestern University, Chicago, Ill.

3:00 p.m. RENAL TRAUMA
Mark A. Immergut, M.D., Hartford, Conn.

4:00 p.m. PYELOGRAM CONFERENCE
Arthur T. Evans, M.D., Professor and Head, Department of Urology, University of Cincinnati, Cincinnati, Ohio

Wednesday, September 16

8:30 a.m. PROBLEMS IN MANAGEMENT OF RENAL HOMOTRANSPLANTATION
William W. Bonney, M.D.

9:15 a.m. MANAGEMENT OF VESICOURETERAL REFLUX
Chester C. Winter, M.D., Professor and Head, Section of Urology, Ohio State University, Columbus, Ohio

10:30 a.m. ANATOMY & PHYSIOLOGY OF BLADDER, TRIGONE & URETHRA—PHYSIOLOGY OF VOIDING & EJACULATION
John A. Hutch, M.D., Clinical Professor of Urology, University of California, San Francisco, Calif.

11:30 a.m. SEPTIC SHOCK
Dean Parker, M.D., Clinical Professor of Urology, University of California, San Diego, Calif.

2:00 p.m. EVOLUTION OF PERIURETHRAL FIBROSIS
Dr. Evans

3:00 p.m. RELATIONSHIP OF PLASMA TESTOSTERONE TO HUMAN SEMINAL FRUCTOSE
Koo H. Moon, M.D.

4:00 p.m. MEGARECTUM AS A CAUSE OF URINARY INFECTION IN CHILDHOOD
Charles A. Hulse, M.D., Clinical Associate Professor of Urology, University of Texas, San Antonio, Texas

4:45 p.m. CLINICAL PATHOLOGICAL STUDY OF PRIMARY URETERAL CARCINOMA
Charles E. Hawtrey, M.D.

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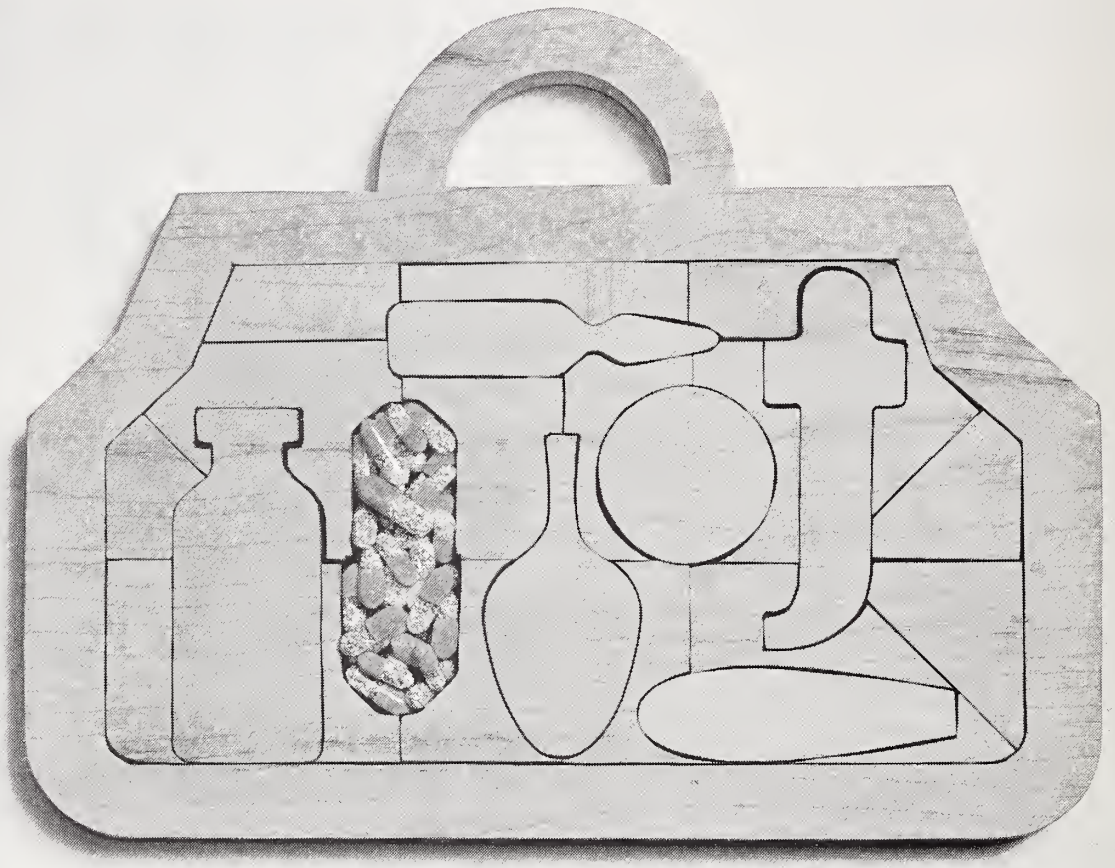
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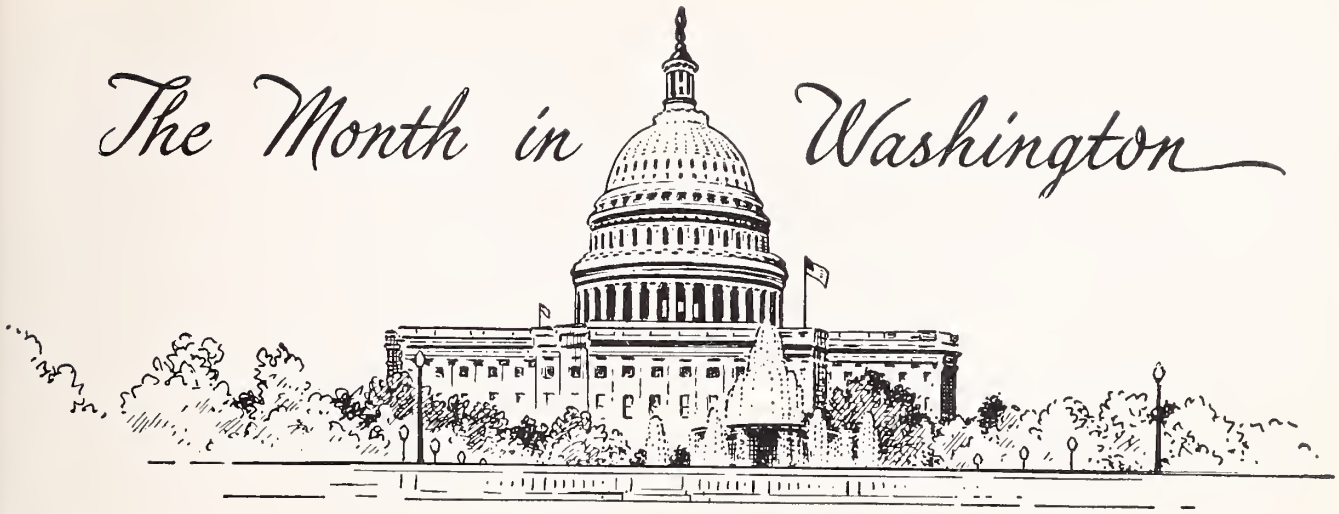
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The Month in Washington



Washington—An American Medical Association proposal for peer review for the Medicare and Medicaid programs drew recent favorable reaction from members of the Senate Finance Committee.

Peer review was one part of a three-point program which Dr. Gerald D. Dorman, now immediate past-president of the AMA, offered in testimony at a Senate Finance Committee hearing on Medicare and Medicaid.

Dr. Dorman and Dr. Julius W. Hill, president of the National Medical Association, testified together. They jointly urged Congress to replace Medicaid with a national health insurance program subsidized by the federal government.

The AMA health insurance proposal, initially approved by the 1968 AMA House of Delegates, is similar to the plan President Nixon included recently in his proposed revised new national welfare program. He said he would send such legislation to Congress early next year.

Congress is not expected to take up this year proposals for national health insurance. But reaction to the peer review proposal was highly encouraging, and prospects for Congressional approval this year appeared good. Sen. Wallace F. Bennett (R., Utah), a Finance Committee member, directed the Committee's staff to work with AMA staff representatives in drafting peer review legislation as an amendment to a bill revising Medicare and Medicaid.

The presidents of the AMA and the predominantly negro NMA gave assurances at the Finance Committee hearing of the medical profession's cooperation in solving the nation's health care problems. It was the first time spokesmen for the two leading medical associations had testified together before a Congressional committee.

Dr. Dorman said "the medical profession hopes to see the nation pursue" the three-point program to provide quality health care for everyone as economically as possible.

Dr. Hill said the insurance plan would work better than Medicaid in the ghettoes. He also defended physicians against accusations that they have been profiteering under Medicaid and Medicare.

The first two parts of the AMA program comprised the association's "Medicredit" health insurance plan. The third, peer review, "is a way to assure both scientific quality and economic reasonableness in the medical and health care people get," Dr. Dorman said.

"Our first program would meet the problems of the Title XIX Medicaid program," Dr. Dorman said. "Under our plan, each low income person or family would receive a certificate for the purchase of a qualified and comprehensive health insurance plan. The protection would be theirs without expense or contribution since the cost of the program would be borne entirely by the federal government.

"The second offers tax credits, on a sliding scale based on the tax liability of a family, for the purchase of qualified health benefits coverage. For those with moderate or higher levels of income, the program would provide cash incentives, through income tax credits, to encourage them to protect themselves against major health care costs.

"The third part of our program calls for a structured peer review mechanism to insure high quality of care and to prevent abuses of the Medicare and Medicaid programs."

Dr. Dorman noted the Committee's staff in a February report on Medicare-Medicaid suggested organized medicine regulate itself.

"We agree, and propose a program providing for professional review of matters bearing on reasonableness of charges for, need for, and the quality of services rendered by, the provider of medical or other health services," he said.

Utah's Senator Bennett said there is deep concern over the high costs of Medicare and Medicaid. He complimented the AMA on advancing peer review as a means of curbing these costs. He said:

"I believe the American people are justifiably concerned over the tremendous costs of health

care. Much of that concern, it seems to me, is a product of a very real feeling that we are not getting what we are paying for. I believe, equally, that much of the apprehension, anxiety, and suspicion now prevalent—for better or worse—with respect to those responsible for health care would disappear if professional standards review organizations were established and functioned effectively. It seems to me that the American people are entitled to know that American medicine shares their concern—and more importantly—proposes to do something substantial about it through means of professional standards review organizations. . . .

"I believe that physicians, properly organized and with a proper mandate, are capable of conducting an ongoing effective review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions. If medicine accepts this role and fulfills its responsibility, then the Government would not need to devote its energies and resources to this area of concern. Make no mistake: the direction of the House-passed social security bill is toward more—not less—review of the need for and quality of health care. I believe my amendment would provide the necessary means by which organized medicine could assume responsibility for that review."

Bennett said that, under his amendment, review groups would have responsibility for reviewing "the totality of care provided patients—including all institutional care." That responsibility he said, would be lodged, "wherever possible and wherever feasible," at the local community level. He said:

"Local emphasis is necessary because the practice of medicine may vary, within reasonable limits, from area to area, and local review assures greater familiarity with the physicians involved and ready access to necessary data. Priority should be given to arrangements with local medical societies—of suitable size—which are willing and capable of undertaking comprehensive professional standards review. . . .

"Under the amendment, the Secretary (of Health, Education and Welfare) could use state or local health departments or employ other suitable means of undertaking professional standards review only where the medical societies were unwilling or unable to do the necessary work, or where their efforts were only *pro forma* or token. Let me emphasize as strongly as possible that the thrust of this proposal is to have physicians, as a group, evaluate physicians and the services they provide and order as individuals."

Bennett said that the review committees should determine that only medically necessary services are provided by physicians, hospitals, nursing homes and pharmacies, and that these services meet proper professional standards.

Disciplinary measures, he said, would be in proportion to the offense and could include: 1) monetary penalties, 2) suspension from federal programs, 3) exclusion from federal programs, 4) civil or criminal prosecution, and 5) steps leading to the suspension or revocation of professional licensure.

Dr. Hill directed his testimony before the Finance Committee mainly to medical care of the blacks and other poor people, particularly in ghettoes. He took issue with the Committee staff report which, he said, "by implication attacked the very physicians working closest to the poor and treating them." He said restrictions upon physicians' fees, as advocated in the report, would make more acute the already critical shortage of physicians in ghettoes.

"To those who read the entire report, there were a number of very complimentary things said about all physicians," Dr. Hill said. "But the primary message, the one seized upon by the press and broadcast across the country, appeared to be that any doctor earning a substantial amount of money from Medicare-Medicaid was somehow cheating both the government and his patients.

"It was bitterly ironic. To work 60 and more hours a week in the ghetto, and to be fairly paid, was suddenly prima facie evidence of wrong-doing.

"The report was also interpreted so that the blame for the rising cost of Medicare-Medicaid was directed at the physician—and particularly those caring for the poor.

"Therefore, we of the National Medical Association take strong exception. The implications and accusations of that report were grossly unfair. It is difficult enough to get physicians to practice among the poor. . . . If these men, professionals committed to providing care, are to be subjected to irresponsible accusations for the size and success of their ghetto practices, it will very soon be impossible to find a doctor among the American poor."

The associations showed the senators a brief movie of physicians practicing in a Chicago ghetto health center and in an Appalachian community clinic.

* * *

The National Communicable Disease Center of the U. S. Public Health Service said that not a single death from polio was reported in the nation last year. It was the first time no death from the disease was reported since 1955 when regular polio surveillance was started. In addition to the absence of a death, the total number of cases of paralytic polio was only 19.

Before the introduction of polio vaccine during the mid 1950's, annual paralytic cases went as high as 21,300 with 1,400 deaths. The number of cases began to dwindle after use of the vaccine became widespread and 1960, with 230 cases, was

the last year when the number of deaths exceeded 100. In recent years, the death toll usually has been between 10 and 20.

Among the 19 paralytic cases last year, only one occurred in a person who had received a full series of anti-polio doses. The exception was a two-year-old suffering from an inborn ability to form protective antibodies against bacteria and viruses.

An estimated 26.5 million doses of vaccine, most of it the oral type, was administered nationwide last year.

A federal health official warned that small outbreaks of polio still are possible in city slums and other areas where it is difficult to achieve 100 per cent immunization. There already have been 11 known cases and one death in the Rio Grande Valley citrus growing region of Texas where there was a problem of convincing parents of the need for immunizing.

Conference on Pediatrics

This Conference on Pediatrics will be held in conjunction with the fall meeting of the Iowa Chapter of the American Academy of Pediatrics on September 9 and 10 at the Memorial Union at the University of Iowa. Sponsors of the Conference are the Department of Pediatrics, U. of I. College of Medicine; Iowa Chapter, AAP, and the Division of Maternal and Child Health, State Department of Health.

Registration fee for the Conference is $35 to AAP members and $40 to non-AAP members.

Unless otherwise indicated, Conference participants are members of the U. of I. faculty.

Wednesday, September 9

9:00 A.M. WELCOME
Donal L. Dunphy, M.D., Professor and Chairman, U. of I. Department of Pediatrics

9:15 A.M. FUTURE DIRECTIONS IN CHILD HEALTH CARE
Robert J. Haggerty, M.D., Professor and Chairman, University of Rochester Medical School, Rochester, N. Y.

10:15 A.M. POST-OPERATIVE AND INTENSIVE CARE OF INFANTS
Judson G. Randolph, M.D., Surgeon-in-Chief, Children's Hospital of District of Columbia, Washington, D. C.

11:00 A.M. FOOD ALLERGY IN INFANTS
Douglas E. Johnstone, M.D., Associate Clinical Professor of Pediatrics, Director, Pediatric Allergy Clinic, University of Rochester

NOON LUNCHEON DISCUSSION GROUPS
Child Health Services—Dr. Haggerty
Functional Constipation—Dr. Randolph
Asthma With and Without Hyposensitization—Dr. Johnstone

2:00 P.M. SMALL DISCUSSION GROUPS
Ambulatory Pediatrics—Sidney Kripke, M.D., and David L. Silber, M.D.
Battered Child—Andre D. Lascari, M.D.
Learning Disorders—Gerald Solomons, M.D., and Charles Johnson, M.D.
Obesity—Lloyd J. Filer, M.D., Charles H. Read, M.D., and Donal L. Dunphy, M.D.
Youth and Drugs—Albert S. Norris, M.D., and Vinton Rowley, M.D.
Cardiac Simulator—Ronald M. Lauer, M.D. and Robert Durnin, M.D.

2:45 P.M. ROTATION OF SMALL DISCUSSION GROUPS

4:00 P.M. BUSINESS MEETING, IOWA CHAPTER, AAP

6:30 P.M. SOCIAL HOUR AND DINNER

Thursday, September 10

9:00 A.M. PERNICIOUS GASTROESOPHAGEAL REFLUX
Dr. Randolph

9:30 A.M. MUSCULAR DYSTROPHY
Hans Zellweger, M.D.

10:00 A.M. MANAGEMENT OF STATUS ASTHMATICUS
Dr. Johnstone

11:00 A.M. MANAGEMENT OF BACTERIAL MENINGITIS
Dr. Haggerty

11:30 A.M. NEONATAL HERPES SIMPLEX INFECTIONS
William E. Bell, M.D.

Survey on Small Community Practice

Findings of an AMA survey of U. S. non-metropolitan physicians (a random sample of 2,468 physicians) included:

- The majority of smalltown practitioners and their wives had smalltown backgrounds; similarly, physicians in communities of 25,000 or more generally were reared in comparably sized cities.

- Influences on choice of practice sites were "best opening," geographic preferences, family and friends, leads from colleagues or others, nearby place of internship and assistance from AMA and medical society placement services.

- 58 per cent were engaged in solo or individual practice, 17 per cent were in group practice and 25 per cent in various combinations of group practice, partnership and salary arrangements.

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Scientific Articles

Evaluation and Treatment of Respiratory Allergy in Iowa

HAL B. RICHERSON, M.D.
PAUL M. SEEBOHM, M.D., and
J. MONTGOMERY SMITH, M.D.
Iowa City

THE PRACTICE OF ALLERGY seems foreboding to many nonallergists. Blame for this lies predominately with allergists, who have often encouraged an aura of mystery by employing strange terms, using unfamiliar techniques and propagating fads and cultism. We are convinced that *the basic principles of allergy are simple.* The following is an attempt to present these principles to the interested physician so he may better handle respiratory allergies with confidence.

The *practical* approach to allergy has evolved over the past 50 years. No recent revolution in diagnosis or treatment has occurred. Current research gives promise that increased understanding of molecular mechanisms will modify the empirical approach. Until that happens the traditional methods will continue to be employed.

Certain limitations in the following discussion should be pointed out. *Allergic rhinitis and extrinsic bronchial asthma are the prime atopic diseases to which the discussion applies. Inhalant* allergens are of major importance in respiratory allergy. Food allergy will not be considered since foods are relatively unimportant in the usual patient with hay fever and/or bronchial asthma; skin testing with foods is rarely helpful in evaluating respiratory allergy and is not recommended for use by the nonallergist.

A bias concerns geographical location, as reflected in the title of this paper. Eastern Iowa shares many of the environmental allergens with the rest of the midwestern and eastern United States. The pollen seasons in Iowa are generally clear-cut and the winters are pollen-free. Other areas of the country, particularly the south and west, have different seasonal patterns. Much of the information which follows, then, is applicable primarily to the midwest. General principles, however, apply wherever atopy is treated.

TERMINOLOGY

A few definitions are necessary. An *antigen* is any substance capable of stimulating the production of antibody (or sensitized cells), and of reacting specifically with the antibodies so induced. Antigens important in clinical allergy may be called *allergens.* The term *atopy* is applied to the group of human diseases which include allergic rhinitis, extrinsic bronchial asthma and some cases of eczema and urticaria.

The authors are in the allergy and applied immunology section, Department of Internal Medicine, at the U. of I. College of Medicine.

The antibody associated with respiratory allergy is referred to as reagin, reaginic antibody or skin sensitizing antibody, and involves a specific immunoglobulin class, IgE.

Ishizaka has reported the identification of a specific immunoglobulin with reaginic activity.[1] This immunoglobulin, which he has named IgE, is distinct from previously described immunoglobulins (IgG, IgA, IgM, IgD). Johansson of Sweden has described a myeloma protein provisionally called IgND which has been shown to be the same immunoglobulin as Ishizaka's IgE. Because of its abundance as myeloma protein in the afflicted patient's serum, antibodies have been produced in animals in quantities sufficient for the development of quantitation of IgE in patients with atopic allergies, and of an in vitro test for allergy.[2]

A classification of rhinitis, to include both allergic and nonallergic types, is outlined in Table I together with a similar scheme for asthma-bronchitis for comparison purposes.

Extrinsic (allergic) rhinitis and *extrinsic bronchial asthma,* both of which may be seasonal or perennial, are specific clinical entities with known etiology, i.e., antigen-antibody reactions involving demonstrable allergens (nearly always inhalants) and reaginic antibodies (IgE class). *Intrinsic (allergic-like) rhinitis* and *intrinsic bronchial asthma* have clinical manifestations very similar to their allergic counterparts (although usually occurring in an older age group), but the etiology and basic mechanisms are obscure; there is no demonstrable antigen-antibody reaction involved. Because these latter diseases are not understood, they are fertile ground for imaginative and often misled diagnostic and treatment fads—such as attributing the etiology to an obscure allergen. It is possible that the pathogenesis is qualitatively different from that of atopic diseases, and that the "intrinsic" diseases are not basically allergic in nature.

Szentvanyi has recently summarized a clever theory which attributes the basic predisposition toward bronchial asthma to a defect in the beta adrenergic receptors.[3] Various extrinsic and intrinsic triggers then fire the charge. The theory is attractive and helps tie together many disparate facts about asthma, but remains to be proved.

Nonspecific vasomotor rhinitis is accompanied by rhinorrhea and nasal stuffiness without the blatant allergic appearance or hyperplastic changes in the nose. *Infectious rhinitis* is caused by a specific infectious agent.

The last two categories in Table I under asthma-bronchitis are variants of bronchitis rather than of bronchial asthma, included to complete the comparison between the nose and the chest. *Nonspecific bronchospasm* may be associated with chronic bronchitis or emphysema, and resembles true bronchial asthma at times. Absence of eosinophilia is a helpful clue in the differential diagnosis. *Infectious asthmatic bronchitis* is an asthma-like episode associated with a specific infection in a patient without underlying bronchial asthma.

TABLE I

A Classification of Rhinitis and Asthma	Skin Tests	Eosinophilia	Family History	Nasal Polyps
Rhinitis				
1. Extrinsic Rhinitis (Allergic)				
A. Seasonal	+	+	+	—
B. Perennial	+	+	+	±
2. Intrinsic Rhinitis (Allergic-like)	—	+	+	+
3. Nonspecific Vasomotor Rhinitis	—	—	—	—
4. Infectious Rhinitis	—	—	—	—
Asthma—Bronchitis				
1. Extrinsic Bronchial Asthma (Allergic)				
A. Seasonal	+	+	+	—
B. Perennial	+	+	+	±
2. Intrinsic Bronchial Asthma (Allergic-like)	—	+	+	+
3. Nonspecific Bronchospasm (With Emphysema and/or Chronic Bronchitis)	—	—	—	—
4. Infectious Asthmatic Bronchitis	—	—	—	—

Chronic obstructive lung disease often presents a problem in differential diagnosis. Pulmonary emphysema and chronic bronchitis are forms of irreversible airways obstruction which should be distinguished from reversible airways obstruction or bronchial asthma. Attempts have been made to distinguish clinical types of irreversible airways obstruction.[4] A general classification of chronic pulmonary airways obstruction is of help in distinguishing clinical entities, with resultant diagnostic and therapeutic implications. Such a classification is detailed in Table II and summarized in Figure 1.

The remainder of this paper will be concerned with our approach to the evaluation and treatment of the patient with allergic rhinitis and/or extrinsic bronchial asthma.

GENERAL DIAGNOSTIC WORKUP

A general medical workup, including a complete history and physical examination, is important in the patient with respiratory allergy. Special points are emphasized below.

History. Several features are of special importance in the history of a patient with respiratory allergy. The nature and pattern of the symptoms at the *onset* of the illness may be particularly revealing, especially if the present symptoms are chronic. Acute seasonal episodes of sneezing, copious rhinorrhea and accompanying eye symptoms are usual with rhinitis caused by pollen allergy. Dust allergy is frequently manifested by sneezing and rhinorrhea when the patient arises in the morning, with subsequent stuffiness. Acute paroxysmal dyspnea at *rest,* usually with cough and wheezing, is characteristic of bronchial asthma. This should be carefully distinguished from exertional dyspnea. A patient with chronic bronchial asthma will typically have bad nights (cough, dyspnea and wheezing), in contrast to the patient with emphysema or chronic bronchitis whose dyspnea is effort-dependent.

Seasonal incidence of symptoms may be diagnostic (Figure 2). Trees pollinate in early spring, grass in early summer and ragweed from mid-August through September. Molds are generally summer-long. Perennial symptoms suggest allergy to house dust, or a dust and mold combination, or possibly animal dander. The patient's memory cannot always be

TABLE II

CHRONIC OBSTRUCTIVE LUNG DISEASE
(Increased Airways Resistance)

I. Reversible Airways Obstruction (= Bronchial Asthma)
(Episodic, non effort-dependent wheezing dyspnea with eosinophilia)

A. Extrinsic Bronchial Asthma
IgE mediated

B. Intrinsic Bronchial Asthma
Etiology unknown

C. Mixed-type Bronchial Asthma
Intrinsic bronchial asthma with additive allergic (extrinsic) factors

II. Irreversible Airways Obstruction (= Emphysema-Chronic Bronchitis)
(Effort-dependent dyspnea without eosinophilia)

A. Emphysema type (Type A; "Pink Puffer"; American Emphysema)
Radiological evidence of emphysema; little sputum production; rare hypercapnia or recurrent heart failure. Total lung capacity is increased and diffusing capacity impaired.

B. Bronchial type (Type B; "Blue Bloater"; British Bronchitis)
No radiological evidence of emphysema (may have changes suggestive of previous inflammatory disease); large quantities of sputum; frequent hypercapnia with recurrent cor pulmonale. Relatively smaller total lung capacity and well-preserved diffusing capacity.

C. Mixed type.
About one-third of patients demonstrate clinical features which cannot separate them into one of the above two categories.

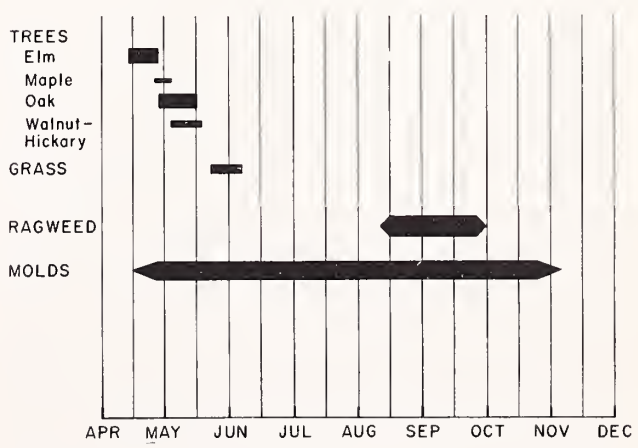


Figure 1. Seasonal chart showing periods when pollens and molds are clinically significant. During winter months (November through April) house dust and animal danders are the only significant inhalant allergens.

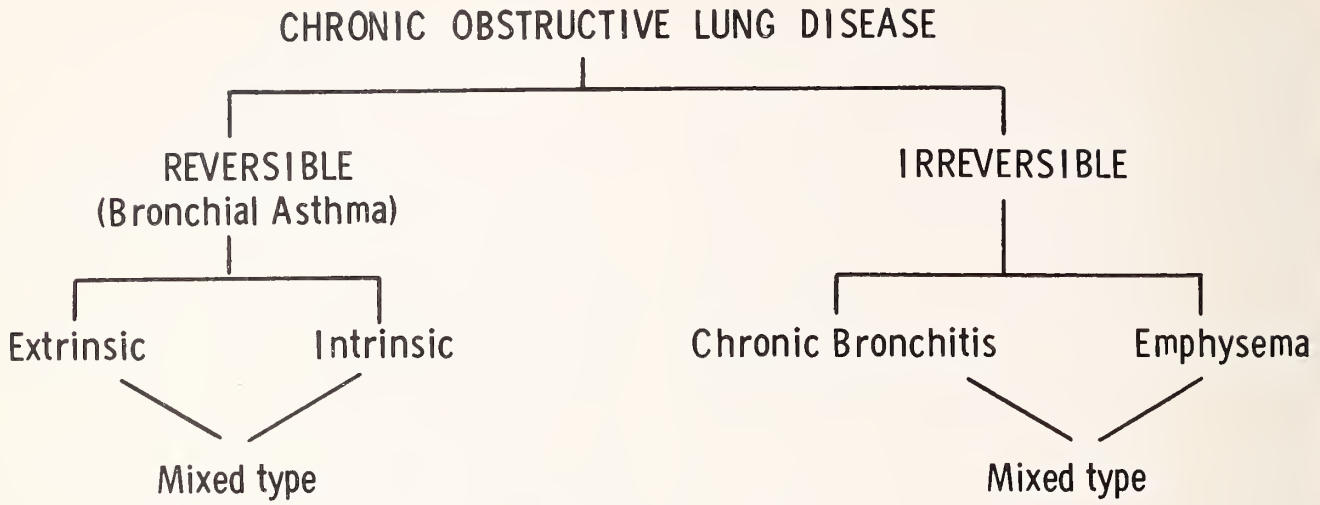


Figure 2. Types and relationships of chronic obstructive lung disease. See Table II for elaboration.

relied on for accuracy, and sometimes a prospective diary is helpful in evaluating environmental influences. Unusual environmental exposures related to the patient's work or daily activities may be important.

Particular attention should be paid to symptoms suggesting infectious complications, such as purulent sinusitis or bronchitis.

The history should be explored for family members exhibiting similar symptoms. Usually there is an atopic family history in patients with atopic respiratory disease.

Physical Examination. A few specific signs should be noted during the general physical examination. The nasal mucosa typically appears swollen and pale, perhaps bluish, in the patient with nasal allergy. If bronchospasm is present at the time of the examination there may be hyperinflation of the chest, prolonged expiration and continuous, coarse, dry rales (wheezes). The presence of fine or medium inspiratory rales should suggest some complicating condition, such as pneumonitis, pulmonary edema, fibrosis or bronchiectasis. It is extremely helpful to grossly inspect a sputum specimen, especially a 24-hour collection; typical asthmatic sputum in the absence of infection is clear, gelatinous, sticky and sometimes frothy. Examination of every patient with chest symptoms should include a vital capacity and some measure of flow rate, such as maximum expiratory flow rate; these measurements are particularly helpful in following a patient's response to treatment.

Laboratory. In our practice we obtain a complete blood count, urinalysis and a chest x-ray on the initial visit. These should be normal in uncomplicated asthma except for eosinophilia. A chest x-ray taken during an asthma episode may show variable degrees of hyperinflation. Nasal secretions and sputum may be examined microscopically for eosinophils; for this purpose the Hansel stain (one minute technique) is quick and simple. Sinus x-rays and bacterial cultures may be required in the occasional patient.

SKIN TESTING

Skin tests are used to verify the clinical impression formed by pertinent features of the history and physical examination. Antihistamines and sympathomimetic drugs such as epinephrine or ephedrine may interfere with skin reactivity. Steroids generally do not. Satisfactory commercial allergy extracts and diluting fluids are available from Center Laboratories, Inc. (Port Washington, N. Y.); Hollister-Stier Laboratories (2201 Curtis Street, Downers Grove, Illinois); and others. For skin testing the physician should be selective in his use of extracts, employing allergens of common occurrence and clinical importance. The most important allergens in Eastern Iowa are house dust, ragweed, alternaria and hormodendrum (the last two are common molds). Animal danders may be useful at times, as may grass and a group of trees. In our clinic we use 18 inhalants (Appendix A). See the following sec-

tion on desensitization for details on dosage and standardization of extract in protein-nitrogen units.

We employ intradermal skin tests exclusively for these inhalants. (Scratch tests are advisable for certain foods because of occasional systemic reactions.) For each intradermal test a disposable tuberculin syringe is used with a No. 26 short (intradermal) bevel disposable needle. A *tiny* amount, just sufficient to raise a pinhead-sized, just perceptible wheal, is injected very superficially into the skin, averaging in volume between 0.01 and 0.02 cc. This is inserted into the outer upper arm, the 18 tests being applied in three rows of six tests. The patient should be lying supine during the skin testing because of the possibility of vaso-vagal syncope, which occurs fairly commonly if the patient is tested while sitting. If an untoward reaction occurs (which is rare), a tourniquet is applied above the area of skin testing, and epinephrine is injected above and below the tourniquet (perhaps 0.2 cc. at each site). As the reaction wanes, the tourniquet is intermittently released until all symptoms have disappeared. Spirits of ammonia should also be available for the much more common vaso-vagal reaction.

Skin tests are read after 10 to 20 minutes. A definite wheal is interpreted as being a slight reaction, a large wheal with pseudopods is marked, and a wheal of intermediate size is moderate. Erythema is relatively unimportant in the interpretation of reactions. Several sites are usually negative and can be used as controls. If all sites are reactive, a control test with diluting fluid is necessary.

The results of the skin tests are then correlated with the clinical findings, and a decision is made regarding desensitization treatment. Marked or moderate skin reactions to the pertinent allergens are usually found in patients with clinical allergy.

DESENSITIZATION (HYPOSENSITIZATION) TREATMENT

Desensitization (or hyposensitization) involves subcutaneous injection of extract containing a specific allergen in increasing quantity to establish tolerance to that specific allergen.

The effectiveness of desensitization treatment has been under discussion for many years. Lowell and Franklin have demonstrated clinical effectiveness of aqueous ragweed injection therapy in ragweed hay fever in double-blind studies.[5, 6] The Johns Hopkins group has reported similar results, and studied the effect of desensitization on *in vitro* histamine release of sensitized cells.[7, 8] These latter studies have provided an increased basis for understanding the mechanisms of desensitization therapy.

Allergens most frequently used in desensitization are house dust, ragweed and the common airborne molds (alternaria and hormodendrum). The dust and molds can be combined in one extract for administration, but the ragweed should be given separately, particularly during buildup of dosage.

The history must be closely correlated with the skin test results before an appropriate decision can be made regarding desensitization. For example, if a patient has symptoms limited to the ragwood season, only ragweed is used in treatment regardless of skin reactivity to other allergens. If symptoms are perennial and the skin is reactive to dust and molds, these are combined in the extract; if in the latter patient the ragweed season is associated with definite aggravation of symptoms, and the ragweed skin test is positive, ragweed is given as a separate extract. If the skin test is positive for ragweed but no aggravation of symptoms occurs during the ragweed season, ragweed is not given. If there is doubt about the accuracy of the history, a symptom diary is recommended for the prospective appropriate season.

Grass and individual tree seasons are rather short in Iowa, lasting perhaps two weeks (See Figure 2). Symptomatic treatment rather than desensitization is usually adequate for these allergens.

Our extracts are standardized in terms of *protein-nitrogen units* (PNU). One PNU or Cooke unit is equivalent to 2 Noon units, 2.6 total nitrogen units, 0.000,026 milligrams of nitrogen, 0.000,01 mg. protein-nitrogen and 1:500,000 dilution of extract (pollen weight by volume). Most of the skin testing is done with 1 PNU, and this is ordinarily a safe initial desensitization dosage.

Dose is increased by an amount generally less than 25 to 50 per cent of the preceding

dose, until maintenance is reached; this is usually 300 to 500 PNU every three weeks.

Routines for extract orders and desensitization schedules are given in the Appendix.

An order for dust extract, for example, is written as follows (CF. Appendix B).

O Dust 70- (1) 100 PNU/cc.
(2) 1,000 PNU/cc.

Follow dust schedule and maintain at 5/10 cc. every three weeks.

The O stands for own (i.e., the patient's own bottle of extract rather than a stock bottle from which we administer desensitization shots to regular clinic treatment patients); 70 is the year the order is written; bottle number (1) contains 100 PNU/cc., and bottle number (2) contains 1,000 PNU/cc. The label on the first weaker bottle will thus read: $\frac{\text{O Dust 70-1}}{\text{100 PNU}}$. The label on the second (stronger bottle): $\frac{\text{O Dust 70-2}}{\text{1,000 PNU}}$.

Similar orders are written for dust and mold mixtures, and for ragweed, except that three dilutions are involved. For a mixture, such as *dust and mold,* the actual ingredients are detailed (Appendix B). The actual labelling of the bottle is as follows:

Bottle 1. $\frac{\text{O Dust \& Mold 70-1}}{\text{10 PNU/cc.}}$

Bottle 2. $\frac{\text{O Dust \& Mold 70-2}}{\text{100 PNU/cc.}}$

Bottle 3. $\frac{\text{O Dust \& Mold 70-3}}{\text{1,000 PNU/cc.}}$

The maintenance bottle (Bottle 3) will contain 1,000 PNU dust, 1,000 PNU alternaria and 1,000 PNU hormodendrum per cc.

Ragweed orders are similar (Appendix B). The weakest dilution contains 10 PNU/cc.; by convention, this weakest bottle is numbered (1/2) because of an older schedule which utilized a stronger maintenance level with bottle (3) containing 10,000 PNU/cc. (See Appendix F). We most commonly employ the weaker schedule of ragweed currently, which consists of three dilutions bearing the following labeling (CF. Appendix B & E).

$\frac{\text{O Ragweed 70-(1/2)}}{\text{10 PNU/cc.}}$ $\frac{\text{O Ragweed 70-(1)}}{\text{100 PNU/cc.}}$ $\frac{\text{O Ragweed 70-(2)}}{\text{1,000 PNU/cc.}}$

The maintenance dose of 5/10 cc. from bottle (2) contains 500 PNU of ragweed extract.

After the start of desensitization treatment, the amount of dosage increase is decided by the amount of local swelling occurring with the previous shot. If excessive swelling occurred (perhaps larger than a 50-cent piece), the dose is held about the same. If a systemic reaction occurs, the next dose should be less than half of that causing the reaction and the patient should be carefully watched. Further increases should be done cautiously, guided by the amount of local swelling. In general, if the preceding dose was well tolerated the next dose can be 1½ times that of the preceding dose. When higher dosage levels are reached the increase should be less. If there is any question, it is best to proceed slowly with increases in dosage or hold at lower levels for maintenance. The printed schedules (Appendix C-F) are satisfactory for most patients. It should be emphasized that every patient has a maintenance dosage level he can accept, and that there is individual variation in this level from patient to patient.

After maintenance level is reached the shots are continued every three weeks for an indefinite period. We do not ordinarily change dosage levels seasonally. If after 6 to 12 months there has been no improvement, dosage may be gradually increased to tolerance, or the shots may be stopped and the patient observed or re-evaluated. If results are good, we usually recommend a continuation of treatment (year around) for about three years; the shots are then stopped and the patient observed for recurrence of symptoms. Symptoms recur in about ⅓ of patients; another course of treatment can be given if the patient and physician think it worthwhile.

If treatment is interrupted the patient's tolerance to injections of extract decreases with time. If there has been a hiatus of six weeks the dose should be about ½ the usual dose. Longer intervals require progressively lower dosage. If three months have intervened it is best to start over with the original schedule. The routine orders for refill of extract are shown in Appendix G. These orders apply to continuation of treatment which is up to date, where only the maintenance bottle is required. The initial dose of the new extract is lower because fresh extract may be more potent than the older extract which the patient had been receiving.

For some time, attempts have been made to develop repository preparations so that fewer shots are necessary and for theoretical adju-

vant effects. These preparations have included water-in-oil emulsions and pyridine extracted alum-precipitated antigens. The effectiveness has been controversial, and we do not prescribe this in our therapeutic programs.

COMPLICATIONS

Adverse reactions to desensitization injections happen occasionally, but should be uncommon and mild if the principles of proper dosage are understood. A reaction to an injection of extract means that *too much antigen has been given,* whether the reaction is manifested as a large local swelling with pain, or a systemic reaction with hives, nasal stuffiness or wheezing. Details should be checked to eliminate a mistake in dosage, such as wrong bottle, misread syringe markings, etc., resulting in excessive dosage administration. If the reaction cannot be explained on this basis, the dose should be cut at least in half for the next injection. If no problem occurs with this injection the dosage level can be cautiously increased (by lesser increments than previously) until proper maintenance dosage is reached, or another reaction occurs. If a second reaction does occur the maintenance dose should be kept below (perhaps ½) this level. An occasional patient will not tolerate dosage levels that the average patient tolerates easily. With these exceptionally sensitive patients, maintenance levels may need to be 1/10 that of the usual recommended dose. Every patient, however, is able to accept maintenance treatment at *some* dosage level. The patient and physician should not give up treatment too early, either because of slow response to treatment or adverse reactions. Dropping the dose level will adequately control the latter. In general, nasal stuffiness following a desensitization shot suggests that the correct antigen is being used but perhaps being increased too rapidly or an excessive dose is being given; this might be considered a good prognostic sign in regard to the results of further treatment.

Unsatisfactory treatment results have several possible causes. The patient may not be allergic, or the wrong allergens may be given for desensitization. If the patient was only questionably atopic on initial evaluation, it is best to stop desensitization after a therapeutic trial of 6 to 12 months. If a new seasonal pattern has developed, a re-evaluation of the responsible allergens should be undertaken. If the poor result seems to be a true treatment failure, perhaps raising the level of maintenance dosage will be helpful; the dose of extract can be gradually increased until either local swelling becomes prohibitive, or therapeutic results are satisfactory. Not all patients will be helped by desensitization treatment, and sometimes stopping treatment reveals that the patient really was improved and wishes to resume treatment. Infection may result in poor results; sinusitis and bacterial bronchitis may require further workup and specific treatment. Irritants such as cigarette smoking may complicate the problem, and these should be eliminated.

Repeated skin testing or testing to new allergens may help clarify an apparent treatment failure if a careful history suggests clues for such testing. Desensitization treatment has little, if any, effect on skin reactivity; therefore, repeated skin testing is not done to assess the effect of treatment.

Close supervision of the patient is important so that maximum benefit can be obtained from symptomatic treatment and control of infection, which are obviously of great importance in the general care of the patient.

SYMPTOMATIC TREATMENT

Allergic rhinitis. Antihistamines and oral decongestants are usually quite helpful in allergic rhinitis and are often employed in combinations such as Co-Pyronil®, Actifed®, etc. Local vasoconstrictors (i.e. nose drops and sprays) are to be condemned, except perhaps for short term use during an acute upper respiratory infection. A steroid nasal spray, containing only steroid, is occasionally helpful and justified for temporary use; this is available as Turbinaire Decadron nasal spray, administered as two squirts in each nostril t.i.d. until relief, and then gradually tapered off.

Bronchial asthma. Symptomatic measures frequently used include SSKI (gr i/gtt), drops 3 to 15 t.i.d. in a glass of water or other liquid; an ephedrine preparation such as Tedral® or Amodrine, tab 1, q.i.d. (Marax® is useful in patients intolerant to barbiturates); and an inhaler (e.g. Medihaler-iso®) which is useful for acute attacks. Aminophylline is effective intravenously, less so rectally and sometimes orally as the elixer (Elixophyllin®). Epinephrine by injection is best reserved for administration by

the physician. Antihistamines are useless and sometimes harmful in bronchial asthma because of their drying affect.

Environmental control. House dust precautions include substitution of a foam rubber pillow for feather or fiber pillow, which tend to be dust catchers. The mattress should be covered with a plastic envelope. Furnaces and ducts should be kept clean and filters used. The bedroom should be sparsely furnished, with elimination of rugs, drapes, bookshelves, stuffed animals and other dust collectors as far as practical. Old over-stuffed chairs should be avoided by the patient. If animal danders are significant allergens, pets should be removed from the house.

During pollen seasons, the patient should ideally stay inside a closed building which is equipped with an air conditioner recirculating inside air to exclude pollen and cooling the air to make the closed environment livable. Anything which regularly aggravates the patient's symptoms should be excluded from the environment if possible; various perfumes, soaps and powders are sometimes in this category, although these usually are not true allergens.

Antibiotics. Purulent sinusitis, bronchitis and other bacterial infections should be promptly treated with appropriate antibiotics. In some patients infections appear to play a dominant role.

Question of adrenal corticosteroids. Steroids are best reserved for those patients in whom other measures fail. One should be able to recognize failure, however, and wisely employ these very valuable agents. They are rarely justified for nasal symptoms (with the possible exception of local application as mentioned previously). In bronchial asthma which proves refractory the physician should be prepared to use steroids.[9] We start most patients on 60 mg. Prednisone daily until the patient is asymptomatic, the chest is clear to auscultation, and the sputum is nil; these desired goals are usually obtainable within 7 to 10 days. We then taper down by one pill daily until a maintenance level of 20 mg. daily is reached. If conditions are stable at this level the dose may be given once daily in the morning. Tapering is then continued more slowly, by taking ½ pill off the daily dose every 5 to 10 days until the patient is completely off steroids or symptoms recur. If the latter occurs the previous dosage level is quickly resumed. If improvement occurs at this higher level it is maintained for a longer period, perhaps 2 to 4 weeks, and then very gradual tapering is attempted. This is continued until successful, or until it is apparent that a minimum maintenance steroid level is necessary. Complications of steroid therapy are well known; proper tapering techniques can assure maximum therapeutic benefit with minimum long-term steroid dosage. It is very useful to follow treatment by means of vital capacity and flow rate measurements at regular intervals.

RETROSPECT AND PROSPECT

The allergic patient with respiratory symptoms is often miserable; he can nearly always be helped. Symptomatic treatment may not be enough, and experience has shown that specific desensitization is worthwhile in the total care of the allergic patient. Hopefully, the basic mechanisms of hypersensitivity diseases and their therapy will be increasingly elucidated by laboratory and clinical studies. New findings may revolutionize the approach to the practice of allergy. Until that occurs, however, traditional methods will continue to be used and should be sufficiently understood by the practicing physician so he can take advantage of them for the benefit of his patients.

For physicians desiring further information on the practice of allergy we recommend Sheldon, Lovell and Mathews: A MANUAL OF CLINICAL ALLERGY; 2nd Edition, W. B. Saunders, 1967. For those interested in basic mechanisms and the exciting realm of immunology, a good place to start is Samter's IMMUNOLOGICAL DISEASES, Little Brown, 1965. Another excellent, recent text is Sherman's HYPERSENSITIVITY: Mechanisms and Management, W. B. Saunders, 1968.

The appendices accompanying this article provide information as to procedures followed by the Department of Allergy, University of Iowa Hospitals.

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APPENDIX A

INHALANTS USED IN ROUTINE INTRADERMAL SKIN TESTING

House dust	10,000	PNU/cc.
Timothy grass	100	
Rabbit epithelium	100	
Feathers	1,000	
Cow epithelium	100	
Alternaria	1,000	
Dog epithelium	100	PNU/cc.
Ragweed	100	
Horse epithelium	100	
Mucor	1,000	
8 trees	100	
Aspergillus	1,000	
Cat epithelium	100	PNU/cc.
Plantain	100	
Hog epithelium	100	
Tobacco	1,000	
Elm	100	
Hormodendrum	1,000	

All concentrations are expressed in Protein-Nitrogen units (PNU)* per cc. of solution. Each skin test is done using 0.01-0.02 cc. of solution, so that the amount of antigen injected into the skin is 1/100 of the above quantity for each test, i.e., 1 PNU for pollens and animal danders, 10 PNU for molds, feathers and tobacco, and 100 PNU for dust.

* PNU = Protein-Nitrogen Unit = 0.000,026 mg. total Nitrogen = 0.000,01 mg. protein-nitrogen.

APPENDIX B

PROCEDURE FOR WRITING EXTRACT ORDERS

O Dust 70-	(1)	100	PNU
	(2)	1,000	PNU

Follow dust schedule and maintain at 5/10 cc. every three weeks.

O Mixture 70-	(1)	10	PNU
	(2)	100	PNU
	(3)	1,000	PNU

Dust, 1 cc.
10,000
Alternaria, 1 cc.
10,000
Hormodendrum, 1 cc.
10,000
Diluting Fluid, 7 cc.

Follow dust and mold schedule and maintain at 3/10 cc. every three weeks.

O Ragweed 70-	(½)	10	PNU
	(1)	100	PNU
	(2)	1,000	PNU

Follow schedule No. 1 for ragweed and give 5/10 cc. every three weeks.

APPENDIX C

Directions for:

1. This preparation contains: DUST
2. Shake before using. Keep in cold place. Never remove rubber caps.
3. Give injections subcutaneously with sterile precautions. A "Tuberculin" syringe is preferable for greater accuracy. Use outer aspect of arms or thighs.
4. Local Reaction: At the site of injection, there is usually redness, swelling, and itching. If this lasts over 36 hours, do not increase the dose the next time, but repeat the dose and then continue to increase as directed unless again contraindicated by local reaction.
5. Constitutional or General Reaction: While such a reaction rarely occurs, it is advisable to wait in the physician's office for half-an-hour after each injection. It begins with itching of the palms of the hands, sneezing and coughing 5 to 30 minutes after the injection. It can be stopped by applying a tourniquet above the site of the injection and by the subcutaneous injection of 4/10 or 5/10 cc. (6 or 8 minims) of adrenalin. This should be given at the onset. Otherwise, the reaction may go on to general hives, hay fever and asthma. The occurrence of a constitutional reaction should be reported to us so that further instructions regarding dosage may be given. In any event, the following dose should be decreased to the size of the one previous to that which caused the reaction.
6. If you are having trouble, please communicate with this office at once giving the date, amount and effect of the last injection. No advice can be given without this information.
7. Please keep an accurate account of date of injection, amount given, extent and duration of local reaction, any constitutional reaction and a daily record of the presence or absence of hay fever or asthma during the season. Return report at end of season, as this information is helpful in revising your dosage for another year.

O Dust 70-1
100 PNU

On receipt give 1/10 cc.
in 7 days give 2/10 cc.
in 7 days give 3/10 cc.
in 7 days give 5/10 cc.
in 7 days give 7/10 cc.

O Dust 70-2
1,000 PNU

Then
in 7 days give 1/10 cc.
in 7 days give 2/10 cc.
in 7 days give 3/10 cc.
in 7 days give 4/10 cc.
in 7 days give 5/10 cc.
and 5/10 cc. once every three weeks.

APPENDIX D

Directions for:

	Dust	Alternaria	Hormodendrum
1. This preparation contains:	1,000 PNU	1,000 PNU	1,000 PNU

Entries 2-7 are identical to Appendix C.

O Mixture 70-1
10 PNU

On receipt give 1/10 cc.
in 7 days give 2/10 cc.
in 7 days give 3/10 cc.
in 7 days give 5/10 cc.
in 7 days give 7/10 cc.

O Mixture 70-2
100 PNU

Then
in 7 days 1/10 cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc.
in 7 days 5/10 cc.
in 7 days 7/10 cc.

O Mixture 70-3
1,000 PNU

Then
in 7 days 1/10 cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc.
and then 3/10 cc. every three weeks.

APPENDIX E

Directions for:

1. This preparation contains ragweed.

Entries 2-7 are identical to Appendix C.

O Ragweed 70-½
10 PNU

On receipt 1/10 cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc.
in 7 days 5/10 cc.
in 7 days 7/10 cc.

O Ragweed 70-1
100 PNU

Then
in 7 days 1/10 cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc.
in 7 days 5/10 cc.
in 7 days 7/10 cc.

O Ragweed 70-2
1,000 PNU

Then
in 7 days 1/10 cc.
in 7 days 0.15 (3/20) cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc.
in 7 days 4/10 cc.
in 7 days 5/10 cc.
and 5/10 cc. once every three weeks.

APPENDIX F

RAGWEED SCHEDULE NO. 2

Directions for:

1. This preparation contains: O Ragweed 70-1, O Ragweed 70-2, O Ragweed 70-3.

Entries 2-7 are identical to Appendix C.

O Ragweed 70-1
100 PNU

On receipt 1/10 cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc.
in 7 days 5/10 cc.
in 7 days 7/10 cc.

O Ragweed 70-2
1,000 PNU

Then
in 7 days 1/10 cc.
in 7 days 0.15 (3/20) cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc.
in 7 days 5/10 cc.
in 7 days 7/10 cc.

O Ragweed 70-3
10,000 PNU

then
in 7 days 1/10 cc.
in 7 days 0.15 (3/20) cc.
in 7 days 2/10 cc.
in 7 days .25 (5/20) cc.
in 7 days 3/10 cc.
and 3/10 cc. once every three weeks.

APPENDIX G

ROUTINE ORDERS FOR REFILL OF EXTRACTS

O Dust 70-2
1,000 PNU

On receipt 1/10 cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc
in 7 days 4/10 cc.
in 7 days 5/10 cc. and 5/10 cc. every three weeks.

O Mixture 70-3
1,000 PNU

Dust, 1 cc.
10,000 PNU
Alternaria, 1 cc.
10,000 PNU
Hormodendrum, 1 cc.
10,000 PNU
Diluting Fluid, 7 cc.
On receipt 1/10 cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc. and 3/10 cc. every three weeks.

O Ragweed 70-2
1,000 PNU

On receipt 1/10 cc.
in 7 days 2/10 cc.
in 7 days 3/10 cc.
in 7 days 4/10 cc.
in 7 days 5/10 cc. and 5/10 cc. every three weeks.

Community Hospital Experience With Emergency Cardiac Resuscitation

L. W. SWANSON, M.D.
Mason City

In 1960 CLOSED-CHEST CARDIAC MASSAGE for cardiac arrest was first described as a means of maintaining adequate circulation until defibrillation could be carried out.[1] The techniques for these life-saving procedures since then have been widely disseminated to the medical and paramedical professions.[2, 3]

In 1967 at St. Joseph Mercy Hospital, Mason City, Iowa (a general hospital of 318 beds), a multidisciplinary group was organized to develop procedures for the emergency application of these new techniques to patients suffering sudden unexpected cardiac or respiratory arrest. The group consisted of internists, thoracic surgeons, an anesthesiologist, a nurse anesthetist, nursing instructors and supervisors and hospital administration.

A *crash cart* was outfitted with a cardiac monitor, internal and external pacemakers, defibrillator, related equipment and appropriate drugs and intravenous solutions. While this was being done, doctors, nurses, aides and orderlies were intensively trained in closed-chest massage techniques and artificial respiration. It was decided that any one directly involved in patient care could initiate the emergency call whenever a patient was found unconscious and pulseless or not breathing. The emergency call designation was established as *Code 4*. A team approach was devised: immediately upon hearing the *Code 4* signal broadcast over the hospital loudspeaker system, physicians, nurses, anesthestists and aides were instructed to converge with the crash cart. The person discovering the arrested patient was assigned responsibility (1) for calling for help *(Code 4)*, and (2) for beginning and continuing closed chest massage and artificial respiration until the team could take over.

With this preparation, the program was initiated in August 1967. In the first few days two patients with acute myocardial infarction developed cardiac arrest from ventricular fibrillation and they were successfully resuscitated and defibrillated. This initial success served to dramatize the effectiveness of the new team approach and the use of new medical techniques. It also served as a morale booster for those instructors and students involved in the in-hospital teaching program.

All new hospital personnel involved in actual patient care are now taught with American Heart Association films and film strips, Resusci-Annie demonstrations and lectures. This is part of the new employee's orientation program.

RESULTS

From August 12, 1967 to December 31, 1969, *Code 4* calls brought the resuscitation team into action 91 times. Forty-three per cent of the patients were successfully resuscitated. In 1967 37 per cent of 19 patients were successfully resuscitated; in 1968 40 per cent of 30 calls ended favorably, and in 1969, 48 per cent of 42 calls were successful.

Approximately 54 per cent of the patients were cardiacs, and among 16 per cent the exact diagnosis was not listed in the hospital records. The percentage of successful resuscitations was also identical in the cardiac and non-cardiac groups. Thirty-six per cent of the patients were under 65 years of age but the ratio of successes to failures was almost identical in both those under and over 65, with a slight edge in favor of the younger group.

Roughly 20 per cent of all resuscitation efforts occurred in the emergency room, 60 per

Dr. Swanson is an internist in private practice in Mason City.

cent in ordinary patient rooms, and the rest in operating, recovery and intensive care suites. Coronary care unit resuscitations are not included in this series as they are all carried out by CCU nurses without *Code 4* team help.

SUMMARY

With closed-chest resuscitation techniques applied promptly by a well-trained team, it has been possible to save nearly half of the patients who have developed sudden unexpected cardiopulmonary arrest in a community hospital. Thorough training of new hospital medical and nursing personnel is needed to accomplish this and frequent retraining sessions are necessary.

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Diagnosis and Management of a Prepartum Female With Acute Symptoms of Hypertension and Uremia

A Case Study

KENNEDY C. FAWCETT, M.D.
JOHN SIBLEY, M.D., and
DAVID WALL, M.D.
Ames

IN APRIL 1964 a gravida III, para II, white female, age 33, presented herself to her obstetrician for her first prenatal examination. Her last menstrual period had been January 19 and her estimated due date was October 26. Her past history as related was essentially normal. She was an identical twin. By coincidence, her sister living in a distant community also reported a pregnancy due just one day following her due date.

The patient reported one previous hospital admission. This was in 1950 when she had entered a hospital because of tiredness, frequency, dysuria and rectal pain. Physical examination revealed a Bartholin cyst which was removed. This apparently was concluded to be the basis of her complaints. A perusal of this hospitalization, however, revealed the urine was reported as containing 1+ albumin and was loaded with white blood cells. She was treated with Furadantin 100 mg. t.i.d. for several days. It is not known whether a follow-up urine was examined.

Her menstrual history was essentially normal with regular 28 day periods lasting four to five days. No difficulty was encountered with them. Her previous delivery records showed two normal deliveries without complications. Both children were living and well. They were seven and nine years of age.

Family history seemed to be noncontributory.

A general physical examination on the first visit showed her weight to be 109 pounds, blood pressure 110/70 and an essentially normal physical picture. No abdominal masses were felt other than a uterus which was estimated to be four months gestation in size. Pelvic examination confirmed a normal pregnant uterus and a Pap smear taken was reported as Class I. Laboratory studies revealed her hemoglobin to be 12.5 grams, white count 9,650. The urine was reported as negative for albumin and sugar and a microscopic contained only epithelial cells. A

The authors are associated with the McFarland Clinic in Ames. Dr. Fawcett is in the Department of Internal Medicine; Dr. Sibley, the Department of Urology; and Dr. Wall, the Department of Obstetrics and Gynecology.

blood Wassermann was negative. This seemed to be a normal early pregnancy in a patient with a history of two previously normal pregnancies, no serious illnesses or operations and normal laboratory findings.

The patient was seen on three monthly prenatal visits in May, June and July. Her weight gain was essentially normal, although somewhat more than the expected two pounds per month. On July 7 her weight was 124½ pounds and her blood pressure 110/70. The uterus was felt to be six months in size. Fetal heart tones could be heard in the lower abdomen. The urine was reported as negative for albumin and sugar.

On August 4 the patient was seen in the office with severe discomfort in the left side of her abdomen. She reported the pain occurred rather suddenly during a vacation in Colorado and was severe enough to necessitate a call to the local physician. Examination at that time was reported as essentially normal. She was given medication for pain and told to go home and relax. However, since the discomfort continued the patient returned home. Examination in the office revealed her blood pressure to be 110/70, uterus the size of a six months pregnancy and fetal heart tones in the right lower quadrant. There was a questionable mass in the left side of the uterus which on palpation was somewhat tender. There was tenderness to palpation on the left costal vertebral angle. Urine examination revealed two to three white blood cells and six to eight red blood cells per high power field; a 1+ albumin and negative sugar was described. A provisional diagnosis of cystopyelitis was made and the patient was placed on Mandelamine 1 gm. q.i.d., forced fluids and rest.

Three days later the patient returned feeling no better and reported being nauseated. A repeat urinary examination revealed the urine to contain 1+ albumin, 2 to 3 white blood cells per high power field and 0 to 3 red cells per high power field. A hemoglobin check revealed her hemoglobin to be 8.3 gm., a tremendous drop from her original 12.5. The white count was 11,600. Her temperature was normal. Abdominal examination revealed normal fetal motion and normal fetal heart tones. The uterus was approximately 6+ months in size, and the questionable mass on the left side was still present. Upon examination it was felt to be a uterine irregularity such as that felt in a pregnancy with a bicornate uterus with one horn of the uterus considerably larger than its mate. Since the patient had not improved markedly on Mandelamine it was felt that the organism was possibly resistant. She was placed on Chloromycetin 250 mg. q.i.d. and given 1 cc. of Proferrin intramuscularly in an effort to correct her hypochromic anemia.

On August 9 at approximately noon the patient was admitted to the hospital with persistent left-sided pain. At this time her temperature was 97.6°, her pulse 148 beats per minute, respirations 20 beats per minute, blood pressure 178/88, the first hypertensive reading. She was very restless, quite pale, and complained of persistent pain in the left side. This caused some grunting respiration. She also complained of persistent nausea with some vomiting. She was given Chloromycetin 500 mg. intramuscularly since the clinical impression was that the patient represented a cystopyelitis. An intravenous infusion of 1,000 cc. of 5 per cent glucose in water was started at 7:00 p.m. At 9:30 p.m. the nurses' notes reported the patient had been on the commode and passed a urine specimen. None was examined, however, and no amount of urine was measured. Throughout the night her blood pressure varied from 150/50 to 176/58. The patient reported she felt miserable, continued to have discomfort and no desire for foods or fluids. The intravenous was continued so that during the first 24 hours of hospital admission she received 3,000 cc. of 5 per cent glucose in water without putting out any urine. At 9:00 a.m. on August 10 the patient complained of severe abdominal pain, particularly on the left side. Abdominal examination at this time revealed definite uterine contractions occurring at four to five minute intervals. Her blood pressure was 210/78 and the aforementioned mass in the left abdomen was still present and quite tender. Point tenderness was still referable to the left costal vertebral angle and the patient was transferred to the labor unit where it was felt she was going to have a premature labor.

Laboratory studies on hospital admission revealed a white count to be 17,650 with 90 per cent polys. A hemoglobin was 7.9 gm. and a urine examination revealed a trace of albumin, a negative sugar, 3 to 6 white blood cells per high power field, 0 to 2 red blood cells per high

power field. On August 10 at the time of the apparent onset of labor a blood uric acid was reported as 10.3 gm. per cent and with these findings a provisional diagnosis of premature labor induced by persistent cystopyelitis and complicated by preeclampsia was then entertained. The patient was sedated with Numorphan ½ mg. every two to four hours as needed for discomfort and started on a unit of whole blood in an effort to correct her anemia. A Foley catheter was introduced into her bladder to facilitate intake and output studies. Throughout the day, the patient required sedation every two to four hours to remain comfortable. Her blood pressure remained elevated with an average pressure of 170/80. Fetal heart tones remained good and uterine contractions seemed of good intensity. At 5:00 p.m. a sterile vaginal examination failed to reveal any definite progress. The cervix was only partially effaced and admitted one finger with difficulty. An amniotomy was performed in an effort to stimulate her progress.

After consultation with the urologist concerning her urinary output and questionable mass on the left side a decision was made to take an intravenous pyelogram. This was done without serious difficulty, and the report revealed a fetus on the right side of the abdomen with the head in the pelvis showing a normal presentation. No renal function was visualized on either side. By 10:00 p.m. the patient had continued her course of regular uterine contractions with no obvious progress. Her urinary output had been zero and she had required frequent sedation to maintain a minimum of comfort. Laboratory studies revealed a blood sodium of 120 mEq., potassium 6.1 mEq., chloride 90 mEq., CO_2 15.3 mEq. and BUN of 72.6. A medical consultation was secured and the internist postulated that the patient had a nonfunctioning right kidney with ureteral obstruction of the left which was responsible for the pain and anuria along with increasing uremia. The obstetrician was quoted as saying, "for my part I was beginning to construct in my mind the most favorable manner in which this case could be presented to a maternal mortality committee."

Because the patient was in active labor, the urologist preferred to wait until the pregnancy was terminated before attempting retrograde pyelograms. An ophthalmologist was also consulted. The eye findings reported marked constriction of the nasal arterioles and it was felt that this was compatible with, but not diagnostic of, early toxemia. Finally at about 10:00 a.m. on August 11 the patient's labor became progressive. Her cervix dilated rather promptly and she delivered precipitously a small premature male infant. The third stage was uncomplicated. The delivery of the placenta appeared quite promptly. However, following this there was some uterine atony and an estimated blood loss of approximately 300 to 400 cc. Intravenous Ergotrate was used with uterine contractions and control of bleeding. The infant was placed in an isolette and prompt pediatric consultation was secured. The infant expired six hours after birth with respiratory failure.

The patient was taken to surgery. The anesthesiologist administered a spinal anesthetic of 10 mg. of tetracaine which produced comfort the patient had not experienced since entering the hospital.

The urologist reported the procedure as follows: A 24 Braasch cystoscope passed without difficulty. The bladder and urethra appeared normal. Left ureteral orifice appeared edematous and a slight flow of urine was seen coming from it. A No. 6 ureteral catheter was passed up the left ureter with ease. Rapid flow of clear urine was obtained after the catheter was passed a short distance up the left ureter. The catheter was passed to 30 cm. and left indwelling. The right ureteral orifice appeared unusually small. A No. 6 catheter could be passed to 30 cm., although it seemed to be rather tight. A moderate flow of clear urine was obtained. The catheters were left in place and held in a Foley catheter in the bladder. Contrast media was injected into both catheters and x-ray exposures made. More contrast media had to be injected on the left in order to visualize the tremendously dilated left kidney and ureter. (See Figure 1.) A very rapid flow of urine continued from the left side. However, flow on the right ceased after 20 cc. Retrograde pyeloureterograms demonstrated a small right kidney with marked cortical atrophy, a dilated pelvis and obstruction at the uretero-pelvic junction; and a huge hydronephrotic kidney on the left, although cause of obstruction was not determined.

Following the operative procedure, the patient was returned to the floor where her fluid



Figure 1

intake and blood electrolytes were closely followed by the attending internist. Her BUN came down to normal within 36 hours, and her general condition improved markedly. Packed red blood cells were used to raise her hemoglobin and a corrective surgical procedure on the left kidney was planned for the near future.

The final obstetrical note was as follows: "I am recording this patient as a case of chronic hydronephrosis unrecognized until the 6½ month of pregnancy. A unilateral functioning kidney with ureteral obstruction resulting in uremia, simulating preeclampsia, and a premature spontaneous birth of a 6½ month fetus which expired after the first six hours of life. As seen in a retrospectoscope which nearly always shows a brighter, clearer picture, the patient never had preeclampsia. The probable mass in the left abdomen noticed even before hospitalization was obviously the large hydronephrotic left kidney. Lastly, future pregnancies do not seem advisable. However, the patient does have one thing going for her in that she has an identical twin with possibly two good kidneys, one of which may be able to be utilized at some future date." An intravenous pyelogram was secured on the identical twin and she was found to have bilaterally normally functioning kidneys.

Following the passage of the ureteral catheters the patient was returned to the general surgical ward for further care. The patient proceeded to go into a marked water diuresis putting out over six liters of urine daily. She was still maintained on Chloromycetin 250 mg. q.i.d. and the patient was given 10 per cent glucose and normal saline at 200 cc. per hour or about 5,000 cc. a day. By August 14, four days later, the BUN went from 75 to 19 mg. per cent, CO_2 went from less than 10 to 25 mEq. per liter and the serum sodium went from 120 mEq. per liter to 135 mEq. per liter. The patient's hemoglobin had fallen to 7.3. She was given 2 units of blood and her hemoglobin rose to 12.6. Catheters were maintained in both ureters and the bladder. There was very little excretion from the right kidney although irrigation demonstrated patency of the catheter. Rapid excretion continued from the left kidney.

On August 14 retrograde pyelograms were repeated. The right kidney was unchanged. The left pelvis was now somewhat smaller; the dilated calyces were visualized and a high insertion of the ureter with constriction at the uretero-pelvic junction was noted. Dilation of the upper ureter was also noted. The patient was still on Chloromycetin. Corrective surgery was advised.

The left kidney was explored. There was extreme hydronephrosis with thin cortex. There was a high insertion of the ureter with constriction at the uretero-pelvic junction. Dense adhesions bound the upper 5-6 cm. of ureter to the pelvis producing further obstruction. Below this point, the ureter was moderately dilated. An eliptical incision was made in the lower pelvis which was anastamosed to a longitudinal incision in the dilated upper ureter. A splinting ureteral catheter was passed down the ureter and brought out through a lower calyx along with a nephrostomy tube. By this date the patient's urinary output had settled down to approximately 2,000 cc. daily. By August 19 the patient began a severe febrile course and the temperature rose to 104°. The source of infection was uncertain. The patient's urine remained unsuspicious for infection. Her

obstetrician did not feel the patient had an endometritis. The patient became very toxic, confused, BUN rose to 45 mg. per cent, sodium 136 mEq. per liter, potassium 3.9 mEq. per liter, Chloride 109 and CO_2 range between 9 and 10.7 mEq. per liter. The abdomen became somewhat distended. The flat plate of the abdomen revealed diffuse small and large bowel air suggesting adynamic ileus. The chest x-ray was negative.

On August 23, the patient received close to six liters of fluid with a urinary output of three liters. The patient became markedly dyspneic, pulse rate was 160 per minute and a gallop rhythm was noted. Over hydration was suspected. It was noted that the patient had been having profuse watery stools. The cause of the patient's fever was diagnosed as staphylococcal enterocolitis. Antibiotics were discontinued on August 23. Cultures were performed from the stool. Staphylococcus coagulase positive was cultured. Bacteria were found which were resistent to Neomycin, Chloromycetin and Penicillin. In the ensuing four to five days the patient received close to six million units of Penicillin intravenously with no apparent effect, unless it was to perpetuate the problem. The patient's intake was markedly curtailed to between 500 and 1,000 cc. daily, 2 cc. of Mercuhydrin was given and the patient was cautiously digitalized. Within 24 hours the patient's clinical picture seemed to be improving. Pulse rate gradually slowed to 120 and then 108 per minute. The gallop rhythm abated, respirations became less labored and the stools gradually decreased and returned to a more normal consistency.

Cultures and sensitivities were performed in three different laboratories, each lab confirmed that the organism was sensitive to Staphcillin and Novobiocin. The patient was started on Novobiocin 250 mg. q.i.d. On August 27 the pulse rate was 96 per minute, respirations were 20, the patient's appetite improved and she was placed on oral intake. Her speech was understandable and she no longer appeared confused. The white blood count returned from 18,000 to near normal limits and repeat lab work of serum electrolytes also returned to normal range. By August 31, the Novobiocin was discontinued because urinary cultures revealed bacteria sensitive to Erythromycin. The patient was placed on Erythromycin 250 mg.



Figure 2

q.i.d. On September 3 a pyelogram through the nephrostomy tube showed the same marked pyelocaliectasis. There was satisfactory drainage into the bladder. (See Figure 2.) The nephrostomy catheter was then clamped. Because of purulent drainage from the incision, Clorpactin irrigations were started with marked improvement.

A repeat pyelogram through the nephrostomy tube on September 8 showed good visualization of the ureter and satisfactory drainage of the pelvis. The nephrostomy tube was removed. There was rather marked drainage of the urine from the tube site. This gradually decreased and voided urine became greater in amount. There continued to be a marked pyuria. A urine culture yielded Staphylococcus sensitive only to Mandelamine which therapy was continued at discharge on September 14. There was a slight urine drainage from her flank. It was felt she could easily be followed as an outpatient. She was discharged on Mandelamine, vitamins and iron.

Over the last four years the patient has been seen on multiple occasions and she remains asymptomatic and doing well. The family de-

cision was made for the husband to have a bilateral vasectomy and the patient was advised to avoid any future pregnancy. She was last seen July 19, 1968 with a hemoglobin of 12.9 and a BUN of 26 mg. per cent. Urine cultures have shown no growth. Urinalyses are now normal and the specific gravity of the urine long maintained at 1.010 was now 1.024.

The early detection of significant renal disease in the multigravid female with no previous complicated pregnancies or past history of renal disease is desirable, but proves difficult. A retrospective analysis raises the question as to what might have been found if the patient's urine had been rechecked after Furadantin therapy in 1950, 14 years prior to this pregnancy. If it had shown continued urinary infection, it is possible that an intravenous pyelogram might have been considered at that time. The urine on her first prenatal visit was normal. Her first six months of pregnancy seemed unremarkable. At the beginning of her seventh month of gestation, the first clue presented itself. Left CVA pain and a questionable mass was palpated. This was considered to be a biocornate uterus, and only two to three white cells and six to eight red blood cells with a 1+ albuminuria were noted. Ignoring a mass of questionable certainty in retrospection, the probability of acute pyelonephritis seemed not unreasonable. This is not an uncommon event in the last two-thirds of pregnancy and is found in approximately 1.5 per cent of all pregnancies.[1]

Cystitis in the female is a common disorder. Most physicians would not perform an intravenous pyelogram on the female patient's first encounter with this disorder. A greater number of physicians routinely order intravenous pyelograms in patients, male or female, who suffer from pyelonephritis and/or CVA pain or recurrent episodes of cystitis.

There is an understandable hesitancy on the part of the attending physician and/or radiologist to expose an unborn fetus to unnecessary irradiation. This fear of x-ray can result in a conservative attitude that may prove radical for both fetus and mother. This point has been aptly illustrated in the above case. G. J. Backly appropriately stated: "Sound urologic practices are not changed by the existence of pregnancy and the management of a urologic complication during this period is only slightly altered in most instances."[2] The average excretory urogram consists of six to seven films. This technique can frequently be altered by the use of a single 10-minute film which would reduce the amount of radiation by approximately four-fifths or 80 per cent, and frequently will provide the information desired. This would assist in making a proper diagnosis and hopefully enable the physician to treat the patient more logically, thus reducing the risk of pregnancy and delivery to both mother and child.[3]

Five days after the obstetrician became aware of the patient's symptoms, the patient became rapidly worse and was hospitalized. By the sixth day the mass in the left abdomen was more prominent. Severe hypertension developed as well as anemia and marked increase in left upper quadrant and left costovertebral angle pain. The patient went into spontaneous premature labor causing a delay in the retrograde pyelographic procedures that would otherwise have been attempted prior to delivery.

The uric acid was 10.3 gm. per cent. This was compatible with the diagnosis of preeclampsia.[4] The ophthalmologist's examination of the retinal arterioles also confirmed that possibility. The probability of bilateral obstructive renal disease was considered. The excretory urogram showed no function as would be expected with this degree of azotemia. This certainly suggested bilateral nonfunctioning kidneys.

These diagnostic considerations were excluded for the following reasons: Because of the palpable mass in the left upper quadrant, preeclampsia was thought not likely, in spite of the retinal artery changes and the elevated uric acid levels. Solitary pelvic kidney was excluded because of the high location of the palpable mass which would not cause difficulty unless it was associated with some other abnormality. The possibility of congenital polycystic kidneys was excluded because of the patient's normal blood pressure present during the early pregnancy.[5] Acute renal cortical necrosis was considered improbable without evidence of hemorrhage or abruptio placenta.[6] Pyelonephritis with necrotizing papillitis is most commonly seen in diabetics. It certainly would not explain the mass felt. Renal cell carcinoma often associated with back pain, hematuria, and

mass in the loin[7] was hopefully excluded because of the bilateral renal failure and lack of hematuria. Ureteral kinking with hydronephrosis could not be excluded, but the physicians in attendance favored the possibility of agenesis of the right kidney and ureteral pelvic stricture of the left kidney with marked secondary hydronephrosis.

The retrograde studies demonstrated the pathology. There was congenital bilateral uretero-pelvic junction obstruction on the right leading to complete atrophy of the kidney. The end-picture may have been the result of congenital hypoplasia rather than secondary atrophy. On the left there was severe secondary hydronephrosis. Presumably, inflammatory changes in the upper ureter produced complete obstruction. Since this occurred in a functionally solitary kidney, anuria ensued.

A basic understanding of normal physiologic changes occurring in the upper urinary tract assists in the analysis of renal problems as experienced by a gravid female. These changes were first recognized by Cruveilhier in 1883,[8] and have been amplified by many authors since. These consist of dilatation of the upper two-thirds of the urinary tract. This results in stasis of urine and back pressure in the renal pelvis. Wagen and Jenkins have shown that the hormonal effects of the placenta are primarily responsible for these changes. Mechanical effects are present as evidenced by the changes where the ureters cross the pelvic brim. The changes are more pronounced on the right. This is attributed to the rotation of the uterus in the direction of the right pelvis. These normal physiologic changes are well tolerated unless there is additional renal disease. It is understandable, therefore, that as in this case with bilateral ureteral pelvic stricture, the right kidney was agenic and nonfunctioning. It is possible that the right kidney met its demise in earlier pregnancies. The left kidney, although still functioning, experienced marked difficulty and manifested itself as a huge hydronephrotic kidney. It is interesting to note that there was ureteral dilation below the point of obstruction at the uretero-pelvic junction. The theory that the hormones of pregnancy cause ureteral dilatation could explain this observation.

Bernstine, Le Blanc and Richardson in 1959 reported a case of giant hydronephrosis in pregnancy.[9] Their case emitted 5,300 cc. of urine and measured 15 by 20 cm. They concluded that although small hydronephrotic kidneys have been reported during pregnancy, such giant hydronephrotic kidneys are rarely reported as having been found during pregnancy.

On August 18 the corrective surgery was performed. The plot thickened as the patient suddenly shifted from secondary polyuria to normal urinary output and over hydration. This resulted in marked congestive heart failure. As the problem of the fluid overload was met, a second iatrogenic problem of enterocolitis confronted us. This was due, most likely, to 16 days of Chloromycetin therapy, averaging 1 to 2 gm. per day. Chloromycetin was stopped. Sensitivities of a staph organism agreed with the Novobiocin therapy, and steroids were withheld. On September 14, after 36 days of hospitalization, the patient proved well enough to be discharged. The physicians in attendance felt pleased but humble.

SUMMARY

Renal disease in the face of pregnancy is to be considered a serious complication. The diagnostic possibilities are numerous, and the care of such a patient frequently requires a multidisciplinary approach. The pitfalls to therapy constantly plague the conscientious physician and morbidity and mortality risk would seem to prove significant.

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Editorials

SUCCESSFUL RUBELLA EFFORTS

The Health Department of the State of Iowa reports that over 520,000 children between the ages of one and 12 years were vaccinated in the recent program of rubella immunization. As of the last week of May the program had been successfully carried out in 98 of the 99 counties.

Iowa physicians are to be commended for their participation in this successful effort and for their cooperation with the State Health Department. In addition to the primary purpose of preventing transmission of the disease to pregnant women and the birth of infants with congenital defects, the campaign produced secondary benefits of great value.

According to Dr. Arnold Reeve, State Health Commissioner, the effort was "one of the greatest demonstrations of community interest and cooperation I've ever seen." The cost of the campaign was in excess of one-half million dollars, most of which was raised locally through the special efforts of various organizations. In several counties the county medical society contributed funds for the purchase of vaccine. Local effort to resolve a problem can only strengthen a community and contribute to its cohesiveness and esteem. This is far superior to placing total reliance on federal support.

The physician's participation in a mass community program will help restore his once almost universally favorable image. This image in recent years has unfortunately become tarnished in many communities. By giving their services for the welfare of the community physicians are presenting convincing evidence of their dedication rather than the suggestion of a mercenary motivation.

Prompted by the success of the rubella immunization program and the genuine cooperative effort and its efficiency, there have been requests from several counties for a similar campaign against rubeola (red measles). Such a project would benefit a large number of children and protect them from the disease and its serious complications.

THE HIGHWAY CARNAGE

These are distressing times for the American people, and one of the most unnecessary and discouraging tragedies is the death and destruction on our streets and highways. One cannot read a paper or hear a newscast without reports of horrible accidents telling of death and injury. Violence has become a part of the American scene.

In these United States during 1969 deaths from traffic accidents totaled 57,000, an increase of 49 per cent from 38,200 deaths in 1960. The number injured were counted in the millions. The economic loss alone is estimated to exceed 13 billion dollars. There are no words which can adequately express or measure the agony, the sorrow or the impact on families and loved ones.

The Office of Public Relations of the Iowa

Editorials continued...

State Department of Public Safety, in a January press release, reviewed the sad story of highway accidents in Iowa during the decade of the sixties. During this period 7,500 people lost their lives, 790 of them in 1969. There were 600,000 accidents resulting in 276,000 injuries, 43,000 of them sufficiently serious to necessitate carrying the victim from the scene. The economic loss to Iowa is estimated to exceed one-third of a billion dollars or 33 million dollars per year.

As one rides on our streets and highways one is impressed by the excessive speed and the motorist's all too often utter disregard for the safety of others. Surely excessive speed is a common factor in the loss of control of the vehicle. Speed, faulty judgment, human error and the consumption of alcohol account for the majority of accidents.

Is speed so fundamental to the American way of life that a few minutes' delay in reaching a destination becomes unthinkable? Is hurry so imperative that speeds of 70 to 80 miles an hour are necessary on our highways? If excessive speed is a factor in the death of 57,000 people on our streets and highways in one year (160 per day), isn't the lowering of speed limits (with rigid enforcement) obligatory?

It is estimated nationally that alcohol is a factor in one-half of all fatal highway accidents. In Iowa 40 per cent of the fatal highway accidents have an alcoholic involvement by at least one of the drivers. As a result of a relentless campaign by the Iowa Highway Patrol, there were 2,736 revocations of drivers licenses in 1969 for operating a vehicle while intoxicated, and an average of somewhat over 2,000 revocations annually in the preceding nine years.

It is somehow very difficult to understand why the American public can be so indifferent and apathetic concerning the carnage on our highways and so vocal about our participation in the war in Vietnam. More are killed and injured on our streets and highways in one year than have been killed and injured in Vietnam since the beginning of our participation in that unwise and unfortunate conflict.

Isn't it time for the silent majority to become aroused? Isn't it time to demand that more serious and more effective effort be made to stop the carnage on our streets and highways? As an initial step the lowering of speed limits with rigid enforcement would be most helpful. More severe punishment and longer denial of a drivers license for driving a car when intoxicated might be a deterrent. Obviously there is a great need for more highway patrolmen and traffic policemen.

ON THE POSITIVE SIDE

The catastrophic earthquake in Peru and its consequences are beyond the comprehension of those of us far removed from its horrors. That it has prompted the finer emotions of millions of people in this country and throughout the world is reported in the NATIONAL OBSERVER of June 29. . . . "Peru's nightmarish disaster has plumbed an immeasurable depth of human concern and almost a month after the May 31 disaster the response has catapulted to astonishing heights, particularly in the United States."

The report tells of millions and millions of dollars raised in this country for disaster relief. Countless tons of medical supplies, food and clothing have been collected by numerous agencies and shipped by air, enough so that Peruvian authorities have asked for a temporary halt until the accumulated supplies can be distributed. Medical units of the army and navy were dispatched immediately to assist in the care of the injured, and helicopters were delivered to lift patients out of the valleys and over the mountains to established or temporary hospitals in cities along the coast.

The appeals for disaster aid continue, by many agencies . . . the Red Cross, church groups, CARE, the Salvation Army, and by concerned individuals and industrial corporations. The need will continue for a long time and it is great. It must not be forgotten that it is estimated that some 60,000 persons were killed, thousands upon thousands injured, some

700,000 left homeless. The hunger and despair and illness defy estimate.

The generous response of the citizens of this country to the disaster in Peru is an encouraging and cheering note in this time of unrest, of an unpopular war, of divisive forces within our land and frequent acts of violence and expressions of hate. May the finer human instincts as expressed in the response to the disaster in Peru prevail and bring order out of chaos, harmony out of dissension, and peace instead of war.

PROFITABLE PROGRAMS FOR YOUTH

In every community there is a need for activities to keep young people busy and to stimulate and motivate them to worthwhile industry. One such activity is the Junior Achievement Program which introduces youth to business and some of its ramifications. In this program 15 or 20 high school students form a small company, sell stock, select a product or service for sale, and operate as a business organization with guidance from adult counselors. JA is a national activity with headquarters in New York; local programs are supported by businessmen who recognize their merit. Such programs are functioning successfully in several Iowa cities. There are between 40 and 50 JA groups actively engaged in "business" in Des Moines. This type of program is also practicable for smaller communities, when undertaken by citizens who recognize the possible benefit to youth.

Another youth organization with great potential is an outgrowth of the Explorer Scout Program of the Boy Scouts of America, now called "Exploring." In many areas high school aged boys lose their enthusiasm for customary Explorer Scout activities and it has been found necessary to introduce them to more intriguing and challenging fields. "Exploring" is an attempt to reach out to young people and bring them into association with adults in various occupational fields, from the professions to auto mechanics and law enforcement. It is designed to help young people learn about various adult vocations and hopefully assist them in the choice of a career. That the program does have an appeal is supported by the fact there are about 50 such posts active in Des Moines. Girls are admitted to certain posts which involve occupational fields of interest to them.

In a recent visit to the west coast the writer had the privilege of seeing a Medical Explorer Post in action. The post is made up of 40 to 50 adolescent boys and girls and it is sponsored by a medical clinic with a staff pediatrician as post adviser. Meetings are held every two weeks throughout the year and programs consist of talks by physicians, demonstrations, the showing of films, and visits to laboratories and medical facilities of interest to the group. Members are urged to serve as volunteers in hospitals, clinics and laboratories. An observer could not fail to be impressed by the enthusiasm of the young people and the participating physicians. Surely this exposure to the field of biologic sciences cannot fail to stimulate an interest and to motivate some of the group to seek a career in a medical or a paramedical field.

A common complaint of youth in a great many communities is "There is nothing to do in our town." Adults can correct this situation by initiative, imagination and industry. The Junior Achievement Program and the Explorer Posts are classic examples of what can be done.


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Editorials continued...

VIEWS ON ANTICOAGULANT THERAPY

Despite many studies to determine the value of long-term anticoagulant therapy following myocardial infarction, it continues to be a controversial subject. It is somehow difficult to understand why one patient is given anticoagulants for only six weeks or three months after an acute infarction and a friend or neighbor may continue on anticoagulant therapy three or four years after a similar or even identical lesion.

Several recent articles have cast considerable doubt on the efficacy or need for long-term anticoagulant therapy following myocardial infarction. In the July, 1969 issue of the NEW ENGLAND MEDICAL JOURNAL, Seaman and a group from the University of Oregon Medical School report their experience in an excellent, randomized, double blind study which revealed that long-term prophylactic anticoagulant therapy did not reduce the mortality rate or the complications.* The study showed more treated patients required hospitalization than patients not receiving anticoagulant drugs. It concluded "no evidence of benefit from long-term anticoagulant prophylaxis after myocardial infarction has been demonstrated."

In the January 18, 1969 issue of the LANCET, Ritland and Lygren report the results of a controlled clinical trial of anticoagulants in a group of 208 patients with myocardial infarction.† By random selection the patients were divided into two groups, one given anticoagulants for three months, the other given the drugs for one year. As a result of this study it was concluded that "no statistically significant difference between the two groups with regard to the death-rate or reinfarction-rate could be demonstrated. There were no differences in the results between patients over and under 60 years of age. The investigation supports the opinion that following myocardial infarction there is no indication for anticoagulant therapy beyond the first three months with moderate intensity of treatment as used in this study."

In the January 31, 1970 issue of the LANCET there is reported a collaborative analysis of long-term use of anticoagulants after acute myocardial infarction.‡ The study represented an analysis of 2,205 male and 282 female patients in nine controlled trials conducted between 1950 and 1965. The various series appeared to be alike in their clinical characteristics. There was not complete agreement among the authors concerning the outcome of the study, however the majority concluded that the consistency of the findings supported the belief that anticoagulant therapy *probably* prolonged life for at least two years. This was for the most part restricted to patients with a history of angina or a previous infarction at the time of admission to the hospital for treatment of their last infarction.

A leading article in the BRITISH MEDICAL JOURNAL of February 28, 1970 reviews the subject of long-term anticoagulant treatment after myocardial infarction and it concludes with the statement:

"While anticoagulants are of value in the treatment of venous thrombosis, this is not true of arterial thrombosis, whether cerebral thrombosis or occlusive arterial disease of the legs. The inherent dangers of this form of treatment together with the absence of any evidence of benefit indicates that the time has come to abandon the use of anticoagulants after myocardial infarction."§

It would appear that clinicians should carefully evaluate their patients receiving anticoagulant therapy and ask themselves, "Is this treatment really necessary?"

* Seaman, A. J., Griswold, H. E., Raume R. B. and Ritzman, L.: Long-term anticoagulant prophylaxis after myocardial infarction. NEW ENG. J. MED., **281**:115-119, 1969.

† Ritland, S., and Lygren, T.: Comparison of efficacy of 3 and 12 months' anticoagulant therapy after myocardial infarction. LANCET, **1**:122-124, 1969.

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§ BRIT. MED. J., **1**:514, 1970.

A HUSBAND'S RESPONSIBILITY

In a letter to the editor in the February 14 issue of the LANCET, a British physician wrote, "In England there are at present more applications for vasectomy than surgeons can satisfy."

It would appear this relatively simple operative procedure should be more widely carried out in this country as a measure to limit the number of children in a family. It is fitting that the husband assume this responsibility as an expression of chivalry toward his spouse and to spare her the risks of "the pill," the necessity for a laparotomy, or the hazards of an abortion.

With so much emphasis on population control and the imminence of world hunger, the practicability of sterilization by vasectomy should be brought to the attention of young people concerned with the problem of limiting the size of their families.

USE CAUTION IN SUNBATHING

With the advent of summer the young and even many of the not so young will sunbathe in scant attire at the beach or swimming pool or even in the backyard. For some reason a suntan has become a badge of health and beauty to American youth.

Dermatologists have emphasized the adverse effects of the sun upon the skin and they point to the faces of the farmer and the sailor and the elderly as classic examples of sun damaged skin.

A recent report* by Dr. Albert M. Kligman of the Department of Dermatology of the University of Pennsylvania deserves the attention of sun worshipers. The purpose of the study was to substantiate that the harmful effects of sunlight begin early and may be severe by age 20. It also sought to show that excessive sun results in "incredible connective tissue disorganization which culminates a long process of growth and decay of elastic tissue predominantly."

The study consisted of doing 5 mm. punch biopsies of groups of males in various age groups from childhood to old age. During the study it was determined that the quality and quantity of elastic tissue visualized by orcein staining was the single outstanding histologic feature of sun damage. It was found that an increase in these fibers long preceded any other histologic changes, and they progressed from simple hyperplasia to physical degeneration.

The author points out that skin cancer occurs most often on exposed surfaces and it is induced by ultraviolet light. This occurs only in a minority of people and fortunately the lesions are curable. However, most white persons cannot escape the ravages of sunlight and for darkly complected persons the changes progress more slowly but the resistance is only partial. Although the clinical evidence of sun damage to the skin may not be apparent for several decades, the cosmetic effects become very apparent at age 60 to 70. The author emphasizes that appearance is important to the well-being of the elderly person and a prematurely aged skin induced by sunlight is a high price to pay for the youthful practice of sunbathing.

Dr. Kligman urges that sunlight be recognized as the villain it is and that youth be admonished as to its ill effects. He recommended certain measures to protect the skin. It was suggested that sunbathing be done before 10 a.m. and after 3 p.m. when the ultraviolet rays are of less intensity than at midday. If exposure to intense sunshine is unavoidable because of occupation or irrepressible zeal for a suntan, exposed areas can be shielded by clothing or by the use of creams containing p-aminobenzoic acid or one of its esters. Even better, according to the author, "a way should be found to counteract the manifest attraction of sunbathing."

* Kligman, A. M.: Early destructive effect of sunlight on human skin. JAMA 210:2377-2380, 1969.

President's Page



Several are the sociologic and economic factors being used to justify a new mold for the medical care delivery system. I refer to the greater demands of an affluent society, to the better informed consumer, to the population explosion, to the activism of youth. Manpower deficiencies are helping to shape the new mold; voluntary and governmental third party medicine is also having an increasing impact.

Changes in the delivery system can not be legislated arbitrarily or unilaterally. Havoc would result. Only with deliverers of service actively involved can changes of a positive and acceptable nature be accomplished.

The medical profession in Iowa has a unique opportunity to inspire and lead in merging old and proved mechanisms with newer concepts. Such leadership will produce for the state a viable medical care delivery system. Under study by the Society at this time is a Foundation for Medical Care, an instrument of the profession with the potential to oversee the economics, utilization and quality of medical care, all to the benefit of the deliverer and consumer of medical services. The Foundation idea appears sound, not radical, it advocates fee for service, free choice, comprehensive coverage, responsible third-party involvement, etc.

Your Society officers are exploring the Foundation concept carefully. I encourage you to follow the consideration of this approach.

President

University Hospitals DRUG LETTER

Anti-Anxiety Agents

RICHARD FINN, M.D.

Throughout recorded history, anti-anxiety agents of one kind or another have been the most common form of treatment of tension and anxiety in normal persons under increased stress. The most widely used drug in the world, ethyl alcohol, is usually taken for this purpose. In modern medical practice, the most efficient and effective treatment for tense and anxious patients is a combination of an anti-anxiety drug and a supportive relationship. Yet physicians are troubled by these drugs and by having to prescribe them.

The anti-anxiety drugs can be divided into two groups. First, the older drugs such as the barbiturates, chloral hydrate, paraldehyde and ethyl alcohol. Second, the newer drugs which are subdivided into three groups: sedating antihistamines such as hydroxyzine (Atarax®-Vistaril®), promethazine (Phenergan®) and diphenhydramine (Benadryl®); the muscle relaxants, which are arranged into two groups, the mephenesin derivatives such as meprobamate (Equanil®-Miltown®) and tybamate (Solacen®-Tybatran®), and the benzodiazepines, chlordiazepoxide (Librium®), diazepam (Valium®) and oxazepam (Serax®). The final group of newer anti-anxiety agents is a miscellany of drugs rarely prescribed. Another group sometimes mistakenly used as anti-anxiety drugs are the non-barbiturate hypnotics introduced during the past 15 years.

Another way to classify anti-anxiety drugs is on the basis of their speed of onset and duration of action. Some authorities in this way match the benzodiazepines with phenobarbital, meprobamate with amobarbital (Amytal®) and most non-barbiturate hypnotics with pentobarbital (Nembutal®), secobarbital (Seconal®), and ethyl alcohol. Such a classification can help in selecting the best drug for a patient, as well as anticipating results of overdosage.

The sedating antihistamines do not match readily with the other drugs named above. Even though they are not anti-psychotics, their central effects in some ways resemble the phenothiazines (Thorazine®, Compazine®, Stelazine®, Mellaril®, etc.) and thioxanthenes (Taractan®, Navane®). Habituees of CNS disinhibition have told me that they will use barbiturates, the muscle-relaxant-type agents, non-barbiturate hypnotics, and ethyl alcohol interchangeably. For they get the effect they want from them all. But they don't get the same effect from the sedating antihistamines, the anti-psychotics or even the sedating tricyclic antidepressants (Elavil®, Aventyl®, Sinequan®), and they will avoid these latter groups for this reason.

The sedating antihistamines and the anti-psychotics do not share the cross-tolerance found among the barbiturates, muscle-relaxants, non-barbiturate hypnotics and ethyl alcohol. Therefore, they should not be used as the primary replacement agent in treating acute drug withdrawal in patients with a physical dependence to one of these depressants. The replacement drug should have a cross-tolerance with the drug being withdrawn. Furthermore, antihistamines and anti-psychotics lower the convulsive threshold, and the major goal of this replacement treatment is to prevent convulsions and the sometimes fatal cardiovascular collapse they may precipitate. For example, in two years of using Valium® in nearly 100 cases of delirium tremens at The University of Iowa Alcoholism Treatment Unit, when the expected mortality was 5 to 15 per cent, there was not one death,[1] an impressive record.

The newer drugs are now more widely used than the older. One reason for this is the idea that the newer drugs can be titrated to reduce anxiety without producing sedation, but this is a measurement beyond scientific validation at this time. Their popularity, however, does seem to relate to their newness and all that it connotes, and to the ratio between LD50 and the therapeutic dose, an estimated two to 10 times greater for the newer compounds compared to the older.

I agree with Klein and Davis' view[2] that the anti-anxiety drugs are most effective in reducing anticipatory anxiety; i.e., the apprehension experienced when looking forward to a confrontation. This might be an examination, the meaning of an accident or serious illness, the sudden loss of a loved one, going into combat, or closing a big deal. A combination of support and drugs will help reduce anxiety so most patients can take positive action with what lies ahead. Some people will also feel somewhat demoralized and the addition of a central stimulant for a brief period may help them. While this describes most tense and anxious patients, there is a small group whose emotional discomfort results from chronic maladaptive personality function. Too frequently they show little response to anti-anxiety drugs, or they have paradoxical reactions, or they develop addictive, dependent or negative behavior.

Some specific drug treatments for mental and

Dr. Finn is an assistant professor in the Department of Psychiatry at The U. of I. College of Medicine. This article appeared initially in the February-March, 1970, issue of DRUG LETTER, a monthly intramural publication of University Hospitals, Iowa City. It is published here by the Clinical Pharmacology Committee at the University and with the permission of the author.

emotional symptoms now exist and, because of this, physicians must consider the differential diagnosis of disorders causing such symptoms before prescribing drugs. Endogenous depressions respond to tricyclic anti-depressants (Tofranil®, Elavil®, Pertofrane®, Norpramin®, Aventyl®, Vivactil®, Sinequan®), except in the most severe cases. Anti-psychotic drugs and anti-anxiety agents only suppress symptoms until such depressions remit spontaneously. The difficult diagnostic problem here is identifying the mild endogenous depression, for it does not present as a classical depression. Noyes and Kolb's description is worthwhile reading.[3] Severe anxiety is often associated with schizophrenia, prior to or in the acute states of psychotic episodes. Phenothiazine, thioxanthene, and butyrophenone (Haldol®) anti-psychotics are the only effective drug treatment. Anti-anxiety agents by themselves do almost nothing unless they are taken in hypnotic doses.

Many doctors consider their tense and anxious patients a troublesome lot.

1) There are so many of them. Doctors in private practice report 18½ per cent of all their patients have an important emotional component to their presenting complaints. If only patients in the middle years are considered, the percentages rise to 35 per cent of females and nearly 25 per cent of males. Their major psychological symptom is anxiety or tension.[4]

2) No one likes to live with uncertainty. The causes of many mental disturbances are unknown. Some anxious patients can't discuss what is bothering them or what their true feelings are; they are "repressing." How is a modern doctor committed to rational, scientific medicine to deal with emotion, repression, anxiety or tension, whatever they are?

3) The diagnostic and treatment process of tense and anxious patients is an uncomfortable one for doctors. Many frequently used diagnostic skills are not applicable. The doctor may consider himself a prisoner of a history he cannot confirm, feel trapped into making a diagnostic statement he cannot fully support, and believe he was sandbagged into a treatment program he will not be able to handle or control.

4) A lot of tense and anxious people are not compliant, cooperative patients. Some who accept prescriptions will not accept advice—after all, a doctor is not a psychiatrist. And if referral to a psychiatrist is suggested, half these patients will refuse and ask the doctor to continue treating them.[4]

5) If the doctor elects to treat by counselling, where will he find the time? If he elects to treat by pharmacological methods, he soon learns he is treating non-specific symptoms by non-specific methods. Suddenly it is 1870.

6) With all these uncertainties and ambiguities, the doctor may become disenchanted with his therapeutic armamentarium, his anxious patients and maybe even himself.

In a discussion of the drug treatment of tense and anxious patients, these six points may seem irrelevant. But the doctor is not a negligible factor in the treatment of these patients. As Rickels[5] has pointed out, the outcome of drug treatment of tense and anxious patients depends on a number of non-specific factors involving the patient, the patient's non-treatment milieu, the type of treatment, the treatment milieu and the doctor. For example, all other factors being stable, if the doctor and the tense patient are favorably disposed toward each other and the treatment method, the short-term results of treatment will be good. The short-term result is usually sufficient because most anxiety states are self-limited.

The AMA Committee on Alcoholism and Addiction and Council on Mental Health[6] have given four examples of physician misuse of prescriptions for these drugs:

1) the prolonged and unsupervised administration of drugs for symptomatic relief.

2) the accession to a patient's demands for increased quantities of drugs, often due to a developing state of tolerance.

3) the transfer from barbiturates to newer compounds in the mistaken belief of safety from abuse.

4) the writing of repeated prescriptions without regard to possible accumulative effects, additive action with other drugs, or the establishment of psychological (habituation) or physical dependence.

Much is made about the habituating propensities of anti-anxiety agents. But, as beauty is in the eye of the beholder, habituation tells you little about a drug. What is of concern is a drug's potential to produce physical dependence, tolerance and addictive behavior.

The new FDA prescribing regulations for these drugs will help, but I believe doctors should be stricter than the regulations require. Prescriptions for any of these drugs should never be open-ended. These prescriptions should be written only for quantities sufficient to cover the interval between visits. The total amount of drug prescribed should be less than the usual lethal dose. If, for any reason, a greater amount must be prescribed, the prescription should be broken into refills that can be obtained only at stated intervals until a designated time when the prescription will lapse.

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INFORMATION FROM THE
IOWA HEART ASSOCIATION

Treatment of Hypertension

HARRIET P. DUSTAN, M.D.

HYPERTENSION SHORTENS life. Even the so-called benign hypertension causes premature death or disability and can scarcely be looked upon as benign. Considering that hypertension is potentially lethal, the question arises as to whether sustained reduction of arterial pressure prolongs life. There are two answers to this question: an unqualified "yes" and a "maybe," depending on whether reference is made to the complications of arteriolar disease or those of atherosclerosis. The most frequent results of hypertensive vascular disease —the term used for the arteriolar disease—are cardiac failure and malignant hypertension. In both instances blood pressure reduction is lifesaving providing, of course, that in the malignant hypertensive renal function is still adequate to sustain life. Clinical experience also indicates that good blood pressure control in hypertensive patients without these complications will prevent their occurrence. In contrast, the effects of antihypertensive treatment on the complications of atherosclerosis are not so clear as on those of hypertensive vascular disease, and here the "maybe" answer has to be given. The equivocation in this answer comes because antihypertensive drug treatment has not been used over a long enough period of time to assess its effects on the complications of atherosclerosis that so frequently accompany hypertension. However, there is some evidence which suggests that strokes, at least, occur less frequently in treated patients.

From the foregoing, the goals of antihypertensive treatment can be stated as: 1) to reduce arterial pressure to normal or as near normal as possible, 2) to prevent the progression of arteriolar disease and control its complications if they are present, and 3) to prevent the development of premature atherosclerosis—or at least to prevent or postpone the development of its complications.

There are a variety of ways to treat hypertension effectively. Some are specific in that they eliminate or block a pressor mechanism and thus reduce arterial pressure to normal. Others can be called non-specific because, although hypertension is greatly lessened, arterial pressure does not become normal. The treatments which in my opinion are specific are both surgical and medical. In a young patient with renal arterial stenosis, a successful operation—either a revascularization procedure or nephrectomy—usually completely eliminates the hypertension. In a substantial number of patients with pheochromocytoma, primary aldosteronism and coarctation of the aorta similar results are achieved by operative treatment. Certain drug treatments also achieve complete normalization of arterial pressure. Thus, in patients with primary aldosteronism, administration of spironolactone eliminates hypertension as surely as does operative removal of the tumor; and in patients with increased activity of the beta-adrenergic component of the sympathetic nervous system, use of a beta-blocking drug such as propranolol not only abolishes the symptoms but also reduces arterial pressure to completely normal levels.

The experience with these "specific" treatments is striking because such results are usually not achieved when the pressor mechanism is not approached directly. For example, contrast the blood pressure reduction achievable by successful operative treatment in a patient with renovascular hypertension with the result produced in the same patient by a drug, like alpha methyl dopa, that suppresses sympathetic vasomotor activity. In the former instance, the operation eliminates the pressor factor(s), while in the latter drug treatment lessens the hypertension but does not eliminate it. The operative treatment is specific, while the drug treatment is nonspecific or empiric.

The fact that most drug treatment of hypertension is empiric is not to say that it is unsuccessful, because substantial reductions in arterial pressure can usually be achieved. There are a number of drugs available which are effective and, for the most part, reasonably easy to take. Two types are most commonly used—oral diuretics and drugs that suppress the activity of the sympathetic nervous system through effects on production, storage or release of the neurotransmitter, norepinephrine. The former group includes chlorothiazide and its derivatives, as well as ethacrynic acid and triamterene; the latter comprise ganglion-blocking drugs, reserpine, guanethidine, alpha methyl dopa and pargyline. Not included in these two groups is hydralazine, which seems to act directly on the arterial wall. The anti-aldosterone drug, spironolactone, has value as nonspecific treatment when used to combat the potassium losing effects of chlorothiazide diuretics.

Dr. Dustan is a member of the research division of the Cleveland Clinic.

When used in adequate doses, these drugs usually achieve good blood pressure control. When more than one drug is used, combination tablets are not the best way to administer the medication because there is need to individualize the dose of each drug. The most frequent combination of drugs is an oral diuretic with another type because usually there is a synergistic effect on blood pressure reduction—the combination achieving a better result than would be expected from purely additive effects of the two drugs. Not more than one type of chlorothiazide diuretic should be given in a treatment regimen, and, also, there is no evidence that giving more than one type of adrenergic-blocking drug—such as combining guanethidine with methyl dopa—adds any benefit.

When it is necessary to reduce blood pressure rapidly, as in patients with cardiac failure, intracerebral bleeding or hypertensive encephalopathy, good results can usually be achieved by the potent peripherally-acting sodium nitroprusside or diazoxide given intravenously. More readily available, but less potent, are preparations of reserpine, hydralazine, methyl dopa, and ganglion-blocking drugs suitable for parenteral administration.

One crucial question in the long-term treatment of hypertension concerns how to judge the effect of treatment. Actually, use of office pressure measurements is usually unsatisfactory, but for certain patients there is no other way. However, many patients can learn to make their own measurements, and this provides a daily record of responses and allows for judicious adjustment of doses whenever indicated. One mistake that many clinicians make is failure to obtain a good pre-treatment arterial pressure record, and this difficulty can be obviated by use of home readings. The technique is easy to learn, and the measurement is no more difficult to carry out than estimation of urinary sugar—information considered a must in the treatment of diabetes.

With home readings, the physician has the advantage of judging the effects of treatment in two situations rather than one because he additionally obtains office readings when the patient visits him. The more detailed record of treatment response that is available the better can the treatment be managed.

In some patients with hypertension of unknown cause, use of non-specific drug treatments detailed in the preceding reduces arterial pressure to normal just as specific treatments do in patients with known types of hypertension. Such responses show that each type of treatment can be specific when properly chosen; the current problem is that, for the most part, there is no sure way to make the proper choice. Currently, the challenge of investigation is to learn enough about the mechanisms of hypertension and how they are interrelated so that specific, rather than empiric, treatments can be given to each hypertensive patient.

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THE DOCTOR'S BUSINESS



Professional Corporations

Comparison of Corporation and Self-Employed Retirement Plan

HOWARD D. BAKER
Waterloo

What is so great about the professional corporation and why does anyone want to incur the related problems? It is different in the type of retirement plan it makes available. We should compare one-by-one the differences between the corporation and self-employed retirement plans in order to understand the advantages of each.

First is the matter of cost and difficulty in establishing a corporate plan as compared to a self-employed retirement plan.

With a professional corporation or association it is necessary to draw up a charter, by-laws, employment contracts, draw up property transfer documents and issue stock. After the organization is created it is then necessary to draft a pension or profit-sharing trust.

As contrasted to the corporation, the partnership wanting to establish a self-employed retirement plan can make their decision today, establish their plan tomorrow and have it approved in a matter of a few weeks. There will ordinarily be no legal fees, no accounting problems and the costs are $5 to $10 annually for maintenance, plus a few cents per participant, per transaction, and a $2 to $5 charge for each distribution made.

From the standpoint of cost and difficulty of establishment, the self-employed retirement plan has a tremendous advantage.

Secondly, the difference in allowable contributions under the two plans is great. Under the self-employed retirement plan a dual maximum of 10 per cent and $2,500 annually is imposed.

Under a corporate profit-sharing plan the maximum is 15 per cent with no dollar limitation. In any year when the contribution is less than 15 per cent, the deficit can be accumulated and carried over to future years.

To illustrate the vast difference in these two provisions, assume four doctors with $260,000 of earnings with four eligible employees earning a total of $18,000. The doctors' top tax bracket is 53 per cent.:

- *Under a 4 per cent SERP they would contribute $720 for their employees at an after-tax cost of $340. For themselves they could contribute $10,000, realizing $5,300 tax savings. Their net savings would be about $5,000.*
- *Under a corporate plan they would contribute 15 per cent of $18,000 or $2,700 for their employees at an after-tax cost of about $1,270. For themselves they could contribute $39,000, realizing nearly $21,000 tax savings. Their net savings would be nearly $20,000.*

In this example, a SERP would result in deferral of professional and investment income of about $195,000 tax in 20 years, and under a corporate plan there would be a deferral of about $760,000 tax in the same period.

These figures demonstrate the vast difference in the contribution provisions of the two plans.

Thirdly, terminations and *withdrawals* under the two types of plans are quite different. Under the SERP, except for death or disability, an owner cannot withdraw his accumulation prior to age 59½—even if the plan itself is terminated, the owner's accumulation must remain to age 59½.

Under a *corporate plan* any employee (including doctors) who terminates his employment at any time can withdraw his accumulation, and if the entire plan is terminated, all participants, *including the owners,* will receive their accumulation. This factor gives the corporate plan greater freedom and avoids the "locked in" feature of the SERP.

Fourthly, as previously outlined, the completely different tax treatment of lump-sum distributions for the two plans is one of the most significant comparative factors. Under a SERP a lump-sum distribution is taxed as ordinary income with a five-year averaging provision. Under the corporate plan, lump-sum distributions are taxed partially as ordinary income and partially as long-

(Please turn to page 589)

Mr. Baker is Manager of the Financial Planning Department for Professional Management Midwest.

Iowa Association of Medical Assistants

Fourteenth Annual Convention In Review

The 14th Annual Convention of the American Association of Medical Assistants, State of Iowa, was as exciting and interesting as the theme, *Yesterday-Today-Tomorrow* promised. The Waterloo girls worked hard and they are to be congratulated on a very successful meeting.

We were pleased once again to have medical assistants in training, from the Area Community Schools in Burlington and Cedar Rapids, join us for the Convention. As they complete their studies and begin their work in the paramedical field, we will welcome them into our organization.

Nancy Hutson, our retiring president, again reminded us of the need to "communicate," as she did at the beginning of her year in office. She also suggested we be alert to the needs of our employers, save valuable time for them and free them from menial office chores whenever possible. With their permission, of course, screen calls carefully and try to distribute the work load a little more evenly.

"Lobbyists don't care to see women elected to the Iowa Legislature," State Senator Charlene Conklin told us. "They are one group that does not wish us to serve. That's because they really don't know what to do with us. They can't really come up to us and say, 'When the session ends today, let's go over to a local watering trough and talk about this,'" she said. Mrs. Conklin explained she first ran for public office because her husband challenged her to do so. She now feels it is the most exciting thing she has ever done. She conceded that women face an uphill battle in winning elections to public offices, but said they have a real function in government and can be effective.

"Women legislators look at the issues differently than the men do," said Mrs. Conklin. "Men think more about the effect a law will have today. We're more inclined to think about how it will affect our children and grandchildren." She urged the group to become active in government and politics, to be informed, to read and to listen. She concluded, "Women's organizations are spinning their wheels and wasting time by sitting around passing resolutions. Women I hear on the radio call-in programs are wasting their time talking about things when they should be doing something about them," she stated.

Mrs. P. H. Tenney, president-elect of the Woman's Auxiliary to the Iowa Medical Society, was an honored guest at our Saturday luncheon. Dr. Craig Ellyson, a Waterloo physician, presented an interesting and informative luncheon talk on "Personal and Family Living." Dr. Ellyson has devoted much of his time to this subject area and has helped to develop various educational programs on family living.

A film strip entitled "Hippie Movement and Drug Abuse" was shown by Dr. Harold Fischer, a Waterloo orthodontist. Following his presentation, Dr. Fischer answered questions from the audience and explained he is working with youth groups trying to impress on them the seriousness of this problem.

We were honored to have Dr. and Mrs. James F. Bishop of Davenport attend our banquet and installation of officers. Dr. Bishop is chairman of our State Advisory Board (and my boss) and brought greetings from the Iowa Medical Society. We sincerely appreciate the Society's continued interest in our organization. It was nice to meet so many of the doctors and their wives from the Waterloo area. Dr. Norman Siderius was an able master of ceremonies and Mr. Jack Bender of the WATERLOO DAILY COURIER entertained with his cartoons of well known public officials as well as some chosen from the audience.

Phyllis Singer was the tonic needed Sunday morning. With her topic, "Women Have Brains, Too," I am sure she didn't see a "sleeper" in her audience! Taking us through her experiences in newspaper work she referred to herself as one of the few woman editors of a woman's page. Many capable women are held back because personnel

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managers feel other women will not work for and with another woman.

"We should be proud," she said, "to have our news and announcements included on the woman's page and not request that it be placed elsewhere because 'it is too important.' " Spiced with anecdotes and "off the cuff" comments, she urged us to make the most of our capabilities. "Contrary to TV commercials," she declared, "the most exciting thing in a woman's life is not which detergent is most effective or which bathroom cleaner kills the most germs!" Her idea of togetherness is not standing at the kitchen sink doing the dishes. She is quite willing to let the automatic dishwasher do that chore so she can relax and enjoy her family. Whether we work by choice, or because of necessity, she admonished us to keep up our appearance, cultivate some outside interests, and make our house a home, for she concluded, "I have yet to see a man leave home for a piece of fried chicken."

And now, meet your new officers:

President—Miss Colleen A. Proffitt, Des Moines, employed by Drs. John Bakody and Robert C. Jones.

President-Elect—Mrs. Marjorie Snyder, Anamosa, employed by Drs. R. Y. Netolicky and C. F. Watts, Cedar Rapids.

Vice-President—Mrs. Ann Underdonk, Davenport, employed by Dr. B. Grimmer.

Secretary—Mrs. Jean L. Gold, Davenport, employed by Urological Associates.

Treasurer—Mrs. Marcine Sanders, Davenport, employed by Drs. E. A. Motto and Erling Larson.

Parliamentarian—Mrs. Jeanne D. Green, Davenport.

Historian—Mrs. Barbara Smith, Cedar Rapids.

Corresponding Secretary—Miss Pam Langford, Des Moines.

Mason City will host the 1971 Convention.

JEANNE D. GREEN

The Doctor's Business

(Continued from page 587)

term capital gains. Periodic or monthly payments distributed to participants are taxed as ordinary income when received under both SERP and corporate plans.

Lastly, vesting provisions are much different under the two plans. Under the SERP, vesting must be immediate and 100 per cent. There is no exception to this rule.

Generally, under a corporate plan vesting is granted on a graduated basis. Vesting can be deferred for a period of years up to 10 and then given 100 per cent. Or vesting can be graduated for example, 10 per cent each year for 10 years. Vesting can follow a desired pattern, for example, nothing the first four years, 50 per cent the fifth year and 10 per cent each year to 100 per cent.

SUMMARY

From the preceding information it is quite obvious that, under the right circumstances, a professional corporation can offer some substantial and attractive tax-saving advantages to a group of doctors.

As consultants, we have established some guidelines or criteria for advising our clients to investigate the merits of incorporating:

(1) A group should have a minimum of two doctors and three is preferable.

(2) A group should have *average profit* per man of at least $35,000, with no one in the group lower than $30,000. (This "guideline" is arbitrary; the higher the profit, the more tax advantage is available.)

(3) In addition to an average income of $35,000 or more, the doctors should collectively be *willing* and *able* to contribute at least 10 per cent of their earnings to a profit-sharing plan. If the doctors average $40,000 income, their tax bracket will be about 42 per cent. This means an average annual contribution of $4,000 to $6,000 per doctor with $1,600 to $2,400 representing tax saved and $2,400 to $3,600 "after-tax" investment. If *all doctors cannot agree on this commitment,* there is no point in proceeding with a corporate plan.

(4) The doctors should *presently be in partnership practice* together, so that they know they can practice successfully as a group. Some people are advocating the combination of several solo practices into a professional corporation. Experience has proved the mortality of this type venture to be extremely high since these doctors have not established success in group practice and incorporation is not an adequate reason for forming a new group.

If your group of doctors meet these four tests and you want to proceed to investigate a professional corporation, a *feasibility study* should be completed next.

If the *feasibility study* is favorable, your group should then contact a legal firm with specific experience in establishing professional corporations and profit-sharing trusts. The extent and quality of competent legal counsel to organize and follow up will probably determine the success of the organization in defending itself before the I.R.S. and the tax court.

STATE DEPARTMENT OF HEALTH

ARNOLD M. REEVE, M.D., M.P.H., COMMISSIONER

1969 Animal Rabies in Iowa

Rabies in animals was reported in 49 counties during 1969. There were 103 cases recorded, slightly less than the 126 cases reported in 1968. In general all areas of the state were involved with fewer reports from southwest counties. Since these reports refer only to laboratory confirmed cases they represent only a fraction of actual incidence of the disease. For various reasons many obviously sick animals suspected of having rabies are not submitted for laboratory examination, and thus are not recorded.

Reporting of the disease in dogs is relatively complete because dogs live in close association with man. If a dog is suspected of having rabies it is likely a laboratory examination of the suspect will be done to help in ascertaining if persons have been exposed to the disease. It is notable that no dog rabies was reported in 1969. This is the first calendar year for as long as records have been kept—more than 50 years—that there has been no reported dog rabies. It is believed the state dog rabies vaccination law which went into effect in 1966 is a major factor in the low incidence of dog rabies. This decline in dog rabies is of considerable public health significance since most animal bites are inflicted by dogs.

A change in the dog rabies vaccination law, effective July 1, 1970, requires that dogs be vaccinated against rabies at six months of age rather than at three months.

Rabies was reported in six different species of animals with skunks leading the list. As in previous years skunks appear to be the main reservoir and disseminator of the disease in Iowa.

The 1969 breakdown by animal species and by county is as follows:

	Cases
Skunk (S)	47
Cattle (K)	32
Cat (C)	12
Bat (B)	8
Horse (H)	2
Fox (F)	2
Total	103

	S	K	C	B	H	F
Adair			1	1		
Benton		2				
Black Hawk	4	1	1			
Boone	1	1				
Bremer	1					
Butler		1	1			
Cedar	1					
Cerro Gordo			1			
Cherokee	1		1			
Chickasaw		2			1	
Clayton	1	1				
Clinton	2	2				
Dallas	1			1		
Davis		1	1			
Decatur			1			
Delaware		1				
Des Moines	1	1				
Emmet	1			1		
Franklin	2					
Greene	1					
Hamilton	2					2
Hancock	4	1				
Hardin	1	2				
Harrison				1		
Henry	2	1				
Howard	1					
Humboldt		1				
Iowa		2	1			
Jackson		1				
Jefferson	2					
Johnson	2					
Keokuk	3	1	1			
Kossuth	1					
Linn		1				
Lyon	1					
Mahaska	1		1			
Marion			1			
Marshall	1	2				
Mitchell	1	1				
Plymouth		1			1	
Polk				4		
Poweshiek	1	1				
Sac		1				
Story		1				
Tama	1	1				
Washington	4	1				
Webster	1					
Winnebago	1					
Worth			1			

Distribution of Immunizing Biologicals, Sera and Antibiotics

The State Department of Health maintains selected immunizing biologicals and certain drugs for distribution in Iowa. These materials are provided as a service to physicians. Distribution is designed to encourage the immunization of children, to control infectious diseases, to provide a source of infrequently used items which local pharmacies may not be able to stock and to provide antibiotics specifically for treatment of venereal disease. Another end of the distribution effort is to encourage reporting of cases of disease which otherwise might escape the Department's notice.

I. DISTRIBUTION

TO PRIVATE PHYSICIANS: Most vaccines, without limit as to quantity, are supplied without charge to private physicians for administration in their offices to persons below 19 years of age.

PUBLIC CLINICS FOR CHILDREN: Appropriate vaccine, without limit as to quantity, is available without charge to Well Child Conferences, School Programs, Head Start Programs and other clinics which have been *approved* by the local county medical society or its committee on immunization. Vaccines for clinics are furnished on request of the person in charge of the clinic. When children are immunized in the offices of physicians of their own choice, the physicians should order the vaccine, since the multidose vials provided cannot be broken down by directors of programs for division among several physicians. Clinics receiving these vaccines are requested not to charge the patient for the vaccine, but may charge a fee to cover costs incidental to administration.

PUBLIC CLINICS FOR ADULTS: Vaccines for these age groups will be supplied on a cost reimbursement basis. Vaccine for county-wide programs may be purchased through the Department.

SHIPMENT OF VACCINE: Except for gamma globulin, which is not damaged by unrefrigerated shipment, and emergency shipments of rabies vaccine, biologicals *will not be dispatched from the State Department of Health between Thursday noon and Monday morning because of delays in transport. NO* order will be accepted for less than 100 doses of oral polio vaccine. This product must be shipped packed with dry ice and transportation charges are prohibitive on smaller orders. Large orders for biologicals to be used in school or area programs should be placed at least two weeks in advance in order to permit sufficient time for procurement and proper handling.

II. IMMUNIZING AGENTS AVAILABLE—INFECTIOUS DISEASES

1. **DIPHTHERIA ANTITOXIN:** For passive immunization of early clinical cases. Product is a horse serum. Available in vials of 10,000 and 20,000 units. Request amount in accordance to weight of patient.

2. **TETANUS AND DIPHTHERIA TOXOIDS COMBINED (aluminum phosphate absorbed) FOR ADULT USE:** (Td) Available in 5 cc. vials—10 doses.

3. **DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE COMBINED (DTP):** Available in 7.5 cc. vials—15 doses.

4. **MEASLES VIRUS VACCINE:** Available in single dose vials, needle and syringe included. Available in 50 dose vials for community-wide programs with administration by jet injectors.

A. LIVE, ATTENUATED—SCHWARZ STRAIN (Lirugen®)

B. LIVE, ATTENUATED—MORE ATTENUATED ENDERS (Attenuvax)

5. **POLIOMYELITIS VACCINE (LIVE, ORAL, TRIVALENT)—(SABIN):** Available in one dose, 10 dose and 100 dose vials. For oral administration.

6. **RABIES VACCINE (DUCK EMBRYO):** (usually 14 1 cc. doses) For active immunization following bite of rabid or suspected rabid animals. May be used for pre-exposure immunization of persons at high risk, e.g. veterinarians, animal handlers, dog catchers, etc.

ANTI-RABIES HYPERIMMUNE SERUM: For use in passive immunization of persons bitten about the face and neck or with bites on other parts of the body within three days after being bitten. It does not replace anti-rabies vaccine but serves as an adjunct in certain situations. Product is a serum of equine origin.

7. **RUBELLA VIRUS VACCINE, LIVE:** Available in single dose vials, needles and syringe included. Available in 50 dose vials for community-wide programs for administration by jet injectors only.

A. STRAIN-HPV 77—DUCK EMBRYO (Lyovac Meruvax)

B. STRAIN-CENDEHILL—RABBIT KIDNEY CELL (Cendevax)

C. STRAIN-HPV 77—CANINE RENAL CELL (Rubella Vaccine. Live—Phillips Roxane, Inc.)

8. **SMALLPOX VACCINE (DRYVAX):** Available in 25 dose vials only.

9. **TYPHOID VACCINE:** Available in 20 cc. vials. For persons in close contact with a known case of typhoid fever or household of a known typhoid carrier. NOT FURNISHED FOR WIDESPREAD USE IN "DISASTER CONDITIONS."

In some circumstances (as in the case of mili-

tary personnel, missionaries, etc.) biologics for immunization against cholera and/or plague may be obtained from the Department if it cannot be obtained locally by the physician.

III. THERAPEUTIC AND PROPHYLACTIC BIOLOGICALS

1. **GAMMA GLOBULIN:** Available in 2 cc. vials. For indigent or medical hardship patients who have been *closely* exposed to known cases of infectious hepatitis, measles or German measles. For patient able to pay, cost reimbursements will be billed to physicians. More detailed policy statement on Gamma Globulin distribution is available upon request.

2. **ANTI-TUBERCULOSIS DRUGS:** (Supplied upon written request by a private physician).

PRIMARY: Isoniazid (INH)—For anti-tuberculosis therapy or chemoprophylaxis of positives, recent converters and other reactors of high risk. Para-Aminosalicylic Acid (PAS)—For anti-tuberculosis therapy only. Streptomycin (SM)—For antituberculosis therapy only.

SECONDARY: Ethambutol (Myambutol®)—For anti-tuberculosis therapy only.

SUPPLEMENT: Pyridoxine (Vitamin B_6)—Used in conjunction with INH regimen.

3. **ANTIBIOTICS—VENEREAL DISEASE CONTROL:** The following drugs are available without cost to physicians for the treatment of reported cases of venereal disease. Requests for drugs should be made directly to the Division of Veneral Disease Control and must be accompanied by case report.

PROCAINE PENICILLIN, AQUEOUS: 2,400,000 units for male and 4,800,000 units for female gonorrhea cases. 4,800,000 units to 12,000,000 units for syphilis cases, depending upon diagnosis. Aqueous penicillin is the drug of choice in the treatment of gonorrhea.

BENZATHINE PENICILLIN G: Distribution restricted to syphilis cases—2,400,000 to 9,000,000 units depending upon diagnosis.

TETRACYCLINE (250 mgm. capsules): Distribution limited to those medically indigent syphilis and gonorrhea cases in which penicillin sensitivity has been definitely established or in cases known to be due to Penicillin resistant organisms.

IV. EMERGENCIES

1. In the event of an emergency which requires large amounts of any of the biologics, sera or antibiotics routinely supplied or some other biologic not routinely supplied, the Department will assist in acquisition and delivery for any physician in the state. Physicians may obtain assistance by calling:

Weekdays between 8:00 a.m. and 4:30 p.m.—Area Code 515-281-3478.

EVENINGS AND HOLIDAYS: Dr. Stanley Hendricks—Area Code 515-279-4231 or Mr. Norman L. Pawlewski—Area Code 515-276-6980 or Mrs. Clara Whetstone—Area Code 515-262-3711.

2. **SNAKE ANTI-VENIN**—Polyvalent anticrotalid: Amount according to weight of patient. For treatment of bites of most American snakes. It is of equine origin. It may be obtained direct from the Department on an emergency basis. Enough of this material for one envenomization treatment is also kept at the following Poison Centers: Iowa Methodist Hospital, Des Moines, Iowa; Bethesda General Hospital, Fort Dodge, Iowa; St. Joseph Hospital, Mason City, Iowa; Dickinson County Memorial Hospital, Spirit Lake, Iowa.

3. **VACCINIA IMMUNE GLOBULIN (VIG):** The American National Red Cross under contract from the Center for Disease Control in Atlanta, Georgia, distributes this material. Volunteer Red Cross Consultants assist in the distribution. Any physician who feels that VIG might be required for a patient should telephone the Commissioner of Public Health, whose name, address and telephone number appear below. If it is agreed that the condition of the patient will benefit from treatment with VIG, the Commissioner will arrange for shipment from the nearest regional blood center. These regional blood centers have 24 hour coverage and are equipped to arrange immediate transportation to the attending physician by the most rapid means available. The Department will assist receipt and delivery.

For assistance in obtaining VIG call: Dr. Arnold M. Reeve, Commissioner of Public Health, Iowa State Department of Health, between 8:00 a.m.-4:30 p.m.—Area Code 515-281-5605, after 5:00 p.m. —Area Code 515-276-3501.

Heads Pathology Department

The appointment of George D. Penick, M.D., as professor and head of pathology at The University of Iowa College of Medicine was announced in July. Dr. Penick succeeds Emory D. Warner, M.D., who last year requested to be relieved of administrative duties.

Dr. Penick has been a faculty member at the University of North Carolina since 1949. He has been a full professor of pathology there since 1963 and also attending pathologist at North Carolina Memorial Hospital. Dr. Penick received the bachelor's degree from the University of North Carolina and the doctor of medicine degree from Harvard University. He trained in pathology at the Presbyterian Hospital in Chicago.

A member of the U. of I. faculty since 1930, Dr. Warner will continue his research and teaching as a professor of pathology.

1969 Encephalomyelitis in Iowa Horses

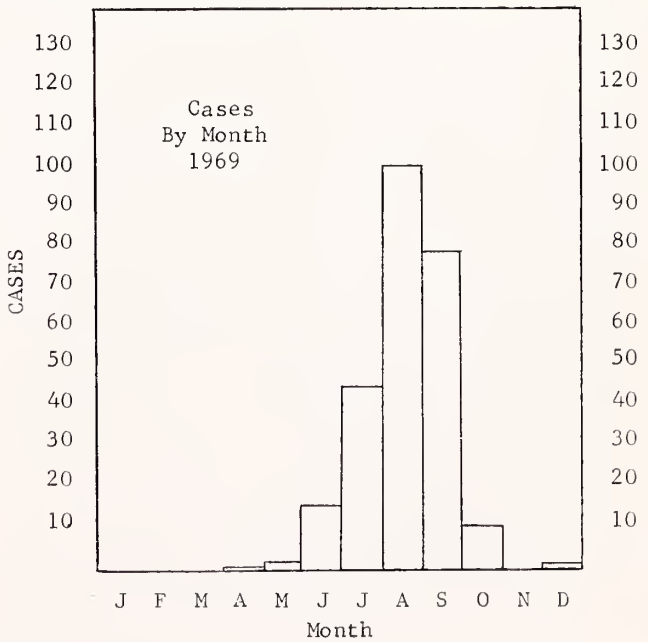
Veterinarians in Iowa have reported the following numbers of clinical cases of viral encephalitis in horses:

1963— 621 cases
1964—1,287 cases
1965— 812 cases
1966— 262 cases
1967— 289 cases
1968— 394 cases
1969— 255 cases

As demonstrated by the accompanying graph, most cases in 1969 occurred in July, August and September, months in which mosquitoes, the common vector, are most abundant.

The county distribution of horse encephalitis is noted in the following listing. Counties not listed had no cases. The number and distribution of horse cases indicate the virus causing the disease is widely disseminated in nature in Iowa. While the disease is not transmitted from horses to man, there is always a possibility of mosquitoes carrying the virus from birds, the most common natural reservoir, to man. No human cases were reported in 1969.

Adair	2	Jasper	4
Appanoose	1	Jefferson	1
Benton	1	Johnson	1
Black Hawk	6	Kossuth	7
Bremer	3	Lee	1
Buchanan	10	Lucas	2
Buena Vista	2	Lyon	3
Butler	2	Marion	1
Calhoun	2	Marshall	1
Carroll	2	Mills	1
Cass	10	Monona	4
Cedar	2	O'Brien	1
Cerro Gordo	8	Page	1
Cherokee	11	Palo Alto	3
Chickasaw	2	Pocahontas	3
Clarke	1	Pottawattamie	25
Clay	9	Poweshiek	2
Clayton	2	Ringgold	1
Clinton	1	Scott	4
Decatur	3	Shelby	1
Des Moines	5	Sioux	4
Emmet	2	Story	14
Fayette	2	Wapello	1
Floyd	2	Warren	13
Grundy	3	Webster	16
Guthrie	1	Winnebago	4
Hancock	6	Winneshiek	1
Hardin	8	Woodbury	12
Iowa	1	Wright	11
Jackson	2		



Morbidity Report for Month of June, 1970

Diseases	June 1970	1970 to Date	1969 to Date	Most June Cases Reported From These Counties
Brucellosis	4	22	17	Dubuque
Chickenpox	155	4,068	3,369	Black Hawk, Polk
German measles	43	1,980	2,191	Linn
Gonorrhea	485	2,520	1,923	Black Hawk, Linn, Polk
Impetigo	12	270	220	Lee, Polk
Infectious hepatitis	19	183	207	Pottawattamie, Scott
Infectious mononucleosis	18	339	358	Polk, Scott
Leptospirosis	1	2	0	Delaware
Malaria, imported				
P. falciparum	1*	3	2	Clinton
P. vivax	1*	6	5	Fayette
Measles	865*	972*	321	Scattered
Meningitis				
meningococcal	2	10	14	Black Hawk, Polk
viral	1	1	1	Dubuque
type unspecified	2	7	9	Dubuque, Iowa
Mumps	166	2,256	3,881	Black Hawk
Pneumonia	43	507	249	Scott
Rabies in animals	11	46	49	Mitchell
Rheumatic fever	3	36	24	Black Hawk
Salmonellosis				
S. enteritidis	2	2	1	Johnson
S. muenchen	1	1	0	Lee
S. panama	1	1	0	O'Brien
S. saint paul	1	2	1	Ringgold
S. typhimurium	3	13	20	Black Hawk, Polk, Scott
S. typhimurium var. copenhagen	1	2	5	Polk
Shigellosis				
S. sonnei	4	38	11	Dallas
Streptococcal infections	280	4,057	2,646	Johnson
Syphilis	33	268	367	Scattered
Tuberculosis, active	10	73	66	Black Hawk, Des Moines, Polk
Whooping cough	2	14	6	Des Moines

* Delayed.

Woman's Auxiliary News

Steps to Meet Health Needs

(The following is excerpted from the speech of Belle Chenault as delivered on April 28, 1970 at the 41st Annual Meeting of the Auxiliary to the Iowa Medical Society.)

There are some progressive steps being taken to more adequately meet the health needs of our communities. For the past two years, the national auxiliary emphasis has been on youth, with additional efforts toward strengthening the family unit wherever possible. We have developed a series of package programs dealing with the problems of youth—Drug Abuse, Teenage Venereal Disease, Smoking, Alcoholism, Block Mother Plan, Sex Education, etc. We have joined with other groups to combat provocative violence on radio and television, apparently with some success.

During the coming year the emphasis nationally will begin to shift to the responsible adult viewing the health needs of her family and her community and working to meet those needs. To undergird this responsibility you will have several new pieces of material prepared by AMA and Auxiliary leaders. One already in use is a "Public Affairs Kit" which includes a plan for recognition of Auxiliary members doing outstanding work in public affairs. As I'm sure you are all aware, this is an important election year, and every physician's wife is needed to take an active interest in good government at every level, as evidenced by PAC membership, work with candidate support committees, activities in the party of her choice, or whatever her time and talents may permit her to do. The "Public Affairs Kit" will help you work more effectively.

A second item will be a new package program on adult physical fitness, including not only exercise programs, but such things as proper nutrition, regular physical examinations, etc. The Chicago AMA convention will feature a panel on this subject the afternoon of June 24.

"Blueprints for Building Membership," which was distributed this past year to state membership chairmen, will be made available in 1970-71 in suitable form for county membership chairmen as well. Although final membership figures are not yet available, the totals are running well ahead of this time last year and 13 states have already passed last year's mark, this despite the dues increase which went into effect this year.

In preparation for summer distribution is a kit designed to guide auxiliaries in setting up blood donor programs where none exist and in promoting already existing programs. Each county auxiliary is being asked to take some part in this essential work, either in drives to increase the number of donors, volunteer services to blood banks, or educational programs as to the need for blood donation.

Perhaps by this preview of new materials, you have already guessed what the four national priority committees will be for the coming year—

AMA-ERF—with continuing emphasis on both the contribution of funds to medical schools and also to the loan guarantee program.

Health Careers—which now boasts a revised package program as well as a new joint project with WASAMA. This new project is called Explo 70's—Exploring the Exploding Health fields of the 70's, and envisions "tour and see" days at medical centers and hospitals under the guidance of the young women of WASAMA, but with the assistance of our own auxiliary members.

Community Health—which will have responsibility not only for health education through the use of package programs, but also for the blood donor program and physical fitness.

Membership—without which we are nothing. And in line with our emphasis on adult responsibility, the importance of the individual member will be stressed.

All this sounds like a complicated and difficult program, but when taken a little at a time it is not that way at all. Remember the saying, "Those who move mountains begin by carrying only a few stones." So don't try everything at once. Pick and choose only those activities which interest your members, which are needed in your community and which have the approval of your sponsoring medical organization. One project done well is best for a small auxiliary. Before you know it you may find that, while carrying those few small stones you have indeed moved mountains—mountains of ignorance, mountains of prejudice, mountains of resentment—or at the very least, you will have tunneled through or built a road around the mountains that are still in place.

Why Belong to the Medical Auxiliary?

Why belong? The Medical Auxiliary is YOU! When you said "I do" to your doctor husband, you assumed with him a responsibility to the medical profession. At no time has medicine needed the deep concern and interest of every one of us more than now.

Join the Medical Auxiliary—you are already one of us. You will receive our WOMAN'S AUXILIARY NEWS, which tells of our aspirations and accomplishments. IN THE PUBLIC INTEREST will come to you and will summarize state health legislation and other health related items. You will also receive the beautifully illustrated national magazine M.D.'S WIFE with its stimulating articles of particular interest to doctor's wives.

In 1922 a resolution creating the Woman's Auxiliary to the American Medical Association stated as its first objective: "To extend the aims of the medical profession through the wives of the doctors, to the various women's organizations which look to the advancement in health and education." Most of us belong to and help support the auxiliary to the hospital where our husband works, in addition to our interest in community health. We can be proud of our many members affiliated with health organizations.

If you have been a member—Come Back! Ours is not an organization from which we retire. We want every doctor's wife to represent her husband. The Auxiliary to the Medical Society—county, state and national—DEPENDS ON YOU.

—MRS. R. L. WICKS
Membership Chairman

Family Power Rx for Crime

(This report was prepared by Mrs. Floyd M. Burgeson, who was President of the Polk County Auxiliary at the time the conference was held.)

The above title was the theme of an April 23 Conference on Crime, Disorder and Delinquency sponsored by the Iowa Farm Bureau Federation and held at the Fort Des Moines Hotel in Des Moines.

Approximately 300 Farm Bureau members plus 200 invited community leaders attended the all-day conference. A wealth of inspiration and knowledge was dispensed during the well planned program. Four very articulate speakers discussed the many phases of crime, its causes, symptoms, results and means of coping with the problems.

The program included:

—*Let's Clobber Crime in Iowa* by George W. Orr, Executive Director of the Iowa Crime Commission. The Commission was formed last year with a legislative mandate to look into all aspects of crime in Iowa and to provide the necessary coordination and action to improve the situation.

—*Crime—Sickness Demanding a Cure* by Thomas E. Bishop, Assistant Director of the Federal Bureau of Investigation.

—*The Politics of Violence* by Elder Marion D. Hanks, an official of The Church of Jesus Christ-Latter Day Saints. The featured speaker, Hanks, is an attorney and an internationally known authority on youth and family relationships. A most talented orator whose message left the audience of women spellbound, Hanks told his listeners they each had a unique role to play in building stronger home lives and better communities.

The following quote by David O. McKay appeared on the first sheet of an information filled packet which was handed to each woman representing an organization: "No success can compensate for failure in the home." Included in the packet was a printed copy of all four speeches to be utilized hopefully as program material by other organizations. The message in each speech was far too vital to file away and be forgotten.

The Iowa Farm Bureau women are to be commended for presenting this conference. Its objective as stated by their state chairman, Mrs. Herbert Johnson, was that of taking "A view towards developing greater appreciation for the law and respect for an orderly society."

Around the Hawkeye State

Black Hawk County

A new steam table and equipment have been purchased by the Medical Auxiliary for Goodwill Industries of Northeast Iowa. Funds for the $500 purchase were derived from the Medical Ball presented under the chairmanship of Mrs. Thomas Spragg. The equipment will serve a twofold purpose at Goodwill: it will aid in establishing a food training course; and it will facilitate the preparation of hot lunches for employees. The following Auxiliary members are also on the Goodwill board: Mrs. R. O. Bailey, Mrs. J. F. Gerken and Mrs. J. L. Kestel.

Pottawattamie-Mills County

Hearing aids were presented to the Iowa School for the Deaf by the Pottawattamie-Mills County Medical Auxiliary in May. They will be used by students at the school.

Scott County

Mrs. J. L. Kehoe recently installed the new officers of the Woman's Auxiliary to the Scott County Medical Society. Those installed were: Mrs. James Donahue, Davenport, president; Mrs. Lester Kimberly, Bettendorf, vice president; Mrs. B. H. Hoenk, Bettendorf, recording secretary; Mrs. Vincent Glowacki, Davenport, corresponding secretary; Mrs. Stephen Weiss, Davenport, treasurer.

Christmas cards sold last holiday season raised $1,300 and made possible a major gift to Friendly House East, Davenport. The entire amount was given for the facility's summer sports program and will be used for the purchase of equipment, etc. Mrs. Marvin Collentine and Mrs. James Holte were co-chairmen of the Christmas card project for the Auxiliary and made the presentation to the Friendly House East.

* * *

Ever Read Your Husband's Journals?

Highly recommend: The Next Ten years, MEDICAL ECONOMICS, four parts beginning in the April 27, 1970 issue. Also: The Training and Use of Allied Health Professionals, MEDICAL OPINION & REVIEW, May 1970.

Lady Legislator Prescribes

"I love it. It's the most exciting thing I've ever done," said Charlene Conklin of her political career. When she spoke at the state convention of the Iowa Association of Medical Assistants on May 16, State Senator Conklin urged her all-female audience to consider running for office.

She conceded women face an uphill battle in winning elections to public offices, but she added they have a real function in government and are effective. "Women legislators look at the issues different than the men do. Men think more about the effect a law will have today. We're more inclined to think about how it will affect our children and grandchildren," said the lady Republican.

Mrs. Conklin encouraged the women to become active in government and politics in a number of ways and declared, "Women's organizations are spinning their wheels and wasting time by sitting around passing resolutions. Women I hear on the radio call-in programs are wasting their time talking about things when they should be doing something about them."

Charlene is the mother of five children and the wife of D. E. Conklin, M.D. of Waterloo. She is a member of the Black Hawk County Medical Auxiliary, a past member of the Iowa Medical Auxiliary Board and was a 1970 AMA delegate.

Musing With Marion . . .

The Dental Auxiliary meeting on May 12 in Des Moines was an enjoyable occasion. A secretary from the American Dental Association Office in Chicago was the featured speaker in the morning. Following a luncheon at the Hotel Kirkwood we were entertained by slides and a display of Christmas plates and collectibles. The dental wives were gracious hostesses and I enjoyed meeting my counterparts from the pharmacy, veterinarian and hospital auxiliary groups. Visiting with a college roommate, a dental wife, Elizabeth Pillars from Des Moines, was an unexpected pleasure.

Kay Kehoe and I worked in a business session with Hazel Lammey that same day. Lots of mileage on that trip!

May brought another highlight: a trip to Milwaukee to the Wisconsin Convention May 18, 19, and 20. It was great fun to be with Char Smollen, Barb Moen and Leona Chesemore, old friends from previous conventions. Barb Moen attended our recent state convention. I learned so much from their business sessions and exhibits, and the social functions were delightful. These I'll share with you later.

The daytime meetings were in Milwaukee's new building for the performing arts—beautiful and unique in many ways. Their repertory theater is excellent. Oliver Goldsmith's *She Stoops to Conquer* was performed in their theater-in-the-round one afternoon.

Lela Mae Young from Kansas City was the national representative at the Wisconsin meeting. By virtue of her landing in the worst room in the Pfister Hotel and my receiving a beautiful one, we wound up rooming together in mine. That was an unexpected fringe benefit and wonderful fun. It was a great trip except for the flight home in atrocious weather that forced our plane to go on to Kansas City, by-passing Ottumwa. After four hours sleep in the Muehlbach's worst room and an early morning trip through fog to get home, I wasn't very easy to live with for a few days. Never was so scared in my life.

Now I'm hoping I will have seen many of you in Chicago at the AMA Annual Meeting, June 21-25 by the time you read this. Best wishes for a happy, relaxing summer.

—MRS. L. H. PREWITT

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501

President-Elect—Mrs. P. H. Tenney, 203 Second Avenue, SW, Independence 50644

Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312

Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228

Editor of THE NEWS—Mrs. J. L. Kehoe, 111 McClellan Blvd., Davenport 52803



Personals



Dr. Frederick C. Brush, a Mason City urologist, spoke at a recent meeting of the Wright County Medical Society. Dr. Brush told of his experiences aboard the S. S. Hope.

Recent presentations by members of The U. of I. Department of Surgery include participation in a symposium on "Cerebral Vessels and Neurosurgery," at Massachusetts General Hospital by **Dr. Herbert B. Locksley**, associate professor of neurosurgery; a talk on the "Iowa Cancer Information Service," by **Dr. Joseph A. Buckwalter,** professor of surgery, at the 10th International Cancer Congress held in Houston, Texas, and at a meeting of the European Dialysis and Transplant Association in Barcelona, Spain, **Dr. Richard L. Lawton,** professor of surgery, discussed "Unusual Intra- and Extra-Corporeal Connections for Vascular Access."

Dr. Gary P. Hayes, of Eldora, spoke at a special program on "Drugs and Drug Abuse," sponsored by the Eldora Teenage Republicans. Dr. Hayes' speech included case histories of persons treated or observed by him in his five years of practice, both in Eldora and Iowa City.

Drs. F. O. W. Voigt and **S. A. Smith,** Oskaloosa physicians, recently taught a one-month course on cardiac care for registered nurses at the Mahaska County Hospital.

Drs. G. W. Bennett, Howard Bos, Kenneth Lemon and **Keith Campbell,** all of Oskaloosa, and **Dr. Ellis Duncan,** of Fremont, recently hosted the semi-annual meeting of the Iowa Clincial Surgical Society in Oskaloosa.

Dr. Robert Kyle, a Cedar Falls neurosurgeon, gave an illustrated report on his visit to the Holy Land, at a public meeting held recently at Christ Church of Cedarloo in Cedar Falls. Dr. Kyle toured the Holy Land for two weeks at Easter time.

Dr. Wendell K. Downing, of Des Moines, was elected to fellowship in the American Proctologic Society at the April meeting of that organization in Hollywood, Florida.

Dr. H. S. Frenkel, of Clarinda, has been named chairman of the board of the Southwest Division of the Iowa Heart Association, and **Dr. John Hoyt** of Creston, has been elected the division's vice-president.

Dr. W. R. Anderson, an associate professor in Department of Obstetrics and Gynecology, at The U. of I. College of Medicine, participated in the 23rd annual meeting of the Upper Midwest Hospital Conference in Minneapolis this Spring.

Dr. Barry Knapp has recently become associated with **Dr. Herbert Caes,** in the practice of pathology in Sioux City. Drs. Caes and Knapp serve St. Joseph Mercy Hospital. Dr. Knapp practiced at Rogue Memorial and Providence Hospitals in Medford, Oregon. A native of Westfield, Iowa, Dr. Knapp is a graduate of The U. of I. College of Medicine, where he also served his residency.

At the annual meeting of the Northwest Division, Iowa Heart Association, **Dr. H. E. Rudersdorf,** of Sioux City, was named president, and **Dr. H. N. Hirsch,** also of Sioux City, was selected president-elect. **Dr. F. B. O'Leary,** of Sibley, is the immediate past president of the organization.

Dr. E. P. Eckart, of Fort Dodge, announced re-

cently a pledge of $10,000 by the Kersten Clinic to the YMCA campaign in Fort Dodge.

Two Waterloo physicians, **Dr. Craig Ellyson** and **Dr. Norman J. Siderius,** were guest speakers at the annual meeting of the Iowa Association of Medical Assitants held in Waterloo in May. The Black Hawk County Chapter of the IAMA hosted the meeting.

Drs. Paul From and **William de Gravelles,** Des Moines physicians, chaired a recent workshop for nursing personnel on "Intensive Management of Stroke." The May workshop was at the Younker Memorial Rehabilitation Center in Des Moines.

Dr. John W. Eckstein, dean of The U. of I. College of Medicine, has been named to a research review group of the National Institutes of Health. Dr. Eckstein will serve a two-year term as chairman of the Cardiovascular "A" Study Section of the NIH Division of Research Grants.

Dr. Craig D. Ellyson, of Waterloo, has received the 1969 Lowry Memorial Award of the Iowa Chapter Arthritis Foundation. Dr. Ellyson was cited for his exceptional service to his patients, especially those afflicted with one of the rheumatic disorders. **Dr. Paul J. Leehey**, of Independence, has been elected to a three-year term on the Foundation's Board of Trustees.

Dr. Paul Seebohm, a professor in the Department of Internal Medicine at The U. of I. College of Medicine, has been appointed as an associate dean by the state Board of Regents.

Dr. Curtis B. Nessa, a Burlington radiologist, was on the 1969 convention program of the state's Physical Therapists Association. The convention was in Burlington.

Dr. Franklin H. Top, professor and head of preventive medicine and environmental health at The U. of I., is the editor and contributor of two new books. Dr. Top edited the 16th edition of REPORT OF THE COMMITTEE ON INFECTIOUS DISEASES, 1970, a publication of the American Academy of Pediatrics. He has edited the volume for the past three editions and has served as a member of the committee since 1955. For his work on the committee and as editor, Dr. Top has been presented the Academy's Clifford G. Greelee Award, a citation and gold medal. Dr. Top is also a contributor and a liaison representative of the Academy for the 1970 edition of CONTROL OF COMMUNICABLE DISEASES IN MAN, an official report of the American Public Health Association.

At a recent meeting of the Health Planning Council of Iowa, **Dr. Homer Skinner,** of Carroll, was re-elected president, and **Dr. E. M. Smith,** of Des Moines, and **Dr. Paul Seebohm,** of Iowa City, were elected to the board of directors.

At the Iowa Heart Association's 1969 delegate assembly and board meeting, **Dr. Luke Chang,** of Mason City, was elected to the IHA board of directors for a two-year term, and **Dr. Dale Harding,** of Eagle Grove, was nominated as an alternate delegate to serve on the board of the American Heart Association. Actual election is at the national level.

Dr. Ronald D. Eckoff, chief of Community Health Services Division, Iowa State Department of Health, was the guest speaker at a Spring dinner meeting at the Waukon Veterans Memorial Hospital. Dr. Eckoff discussed Iowa's home health care services.

The 50th anniversary of Mason City's St. Joseph Mercy Hospital medical staff was observed in May with a symposium on "The Community Hospital in Medical Education and Service—Today and Tomorrow." **Dr. James Hendricks,** president of the staff, presided. **Dr. Richard M. Caplan,** director, Office of Medical Education, U. of I. College of Medicine, and **Dr. Harry B. Weinberg,** former coordinator of the Iowa Regional Medical Program, participated. **Dr. John K. MacGregor,** of Mason City, was chairman of the anniversary planning committee.

Dr. Ian M. Smith, professor of internal medicine at The U. of I. College of Medicine, spoke on "The Epidemiology and Clinical Features of Brucellosis," at a recent symposium of the El Paso (Texas) Medical Society and Beaumont Army General Hospital. The symposium was sponsored by the National Communicable Diseases Center.

Dr. Henry G. Decker, chief of staff of the VA Hospital in Des Moines, has retired. Dr. Decker served as chief of staff from Oct. 1, 1958, until his recent retirement. Prior to 1958, he was in private practice in Des Moines as a neurosurgeon and served then as a consultant at the VA Hospital.

Dr. William W. Jones, associated with the Kersten Clinic in Fort Dodge, has completed examinations in general surgery and is now a diplomate of the American Board of Surgery, certified in general surgery. An Ames native, Dr. Jones received his M.D. degree at the U. of I. College of Medicine in 1963 and took his internship and surgical residency at Salt Lake City, Utah.

Fourteen medical students received awards at the annual University of Iowa Medical Convocation. **Dr. William O. Rieke,** then Dean pro tem, presided at the Convocation and administered the Physician's Oath to 110 new physicians. The Convocation address, "Medicine: A Beginning and a Challenge," was delivered by **Dr. Rubin H. Flocks,** professor and head of the Department of Urology.

Dr. James A. Clifton, professor and vice-chairman of the Department of Internal Medicine at the U. of I., has been appointed head of the department. Dr. Clifton succeeds **Dr. William B. Bean,** who was professor and head of the department for 21 years. Dr. Bean will become the first Sir William Osler Professor of Medicine at the U. of I. Dr. Clifton is currently president of the American Gastroenterological Association.

Dr. Sidney A. Cohen, of Sioux City, gave the congratulatory message at commencement exercises for the graduating class of St. Vincent Hospital School of Nursing and X-Ray Technology. Dr. Cohen is president of the medical staff at St. Vincent's Hospital.

Dr. Sidney Sands has been appointed director of medical education at Broadlawns Polk County Hospital in Des Moines. Dr. Sands will continue his current half-time position as director of Broadlawns psychiatric services, a post he has held since 1956.

Dr. D. G. Sattler, of Kalona, has recently been appointed to the Aerospace Medical Association, a Division of the Federal Aviation Administration. Members of this association are qualified to perform pilot examinations and serve on committees investigating aircraft accidents.

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Recknor Elected NABSP Director

William B. Recknor, executive director of Iowa Medical Service (Blue Shield), has been elected to the Board of Directors of the National Association of Blue Shield Plans. Mr. Recknor will serve for one year as the representative from District X which encompasses the states of North Dakota, South Dakota, Nebraska, Minnesota, Wisconsin and Iowa.

The NABSP Board consists of 36 members including two from each of 11 districts and 14 at large members.

A past secretary of District X, Recknor will begin his service formally by attending the NABSP Board meeting in September. He is a member of the NABSP Committee on Experimentation in Health Care.

Dr. V. B. Malay, a surgeon and general practitioner, formerly with the VA Hospital in Phoenix, has joined **Dr. C. C. Griffin** in the practice of medicine at Dyersville.

Dr. Bernard Diamond, a Waterloo orthopedic surgeon, was recently selected to attend a two-week residency seminar for professional writers at the University of Colorado. Selection to the program is based upon past writing accomplishments and competition with applicants from throughout the country. Dr. Diamond, who has written several one-act plays and a three-act comedy-tragedy, submitted "The Contest," a one-act science fiction comedy.

Dr. Paul M. Seebohm, professor of internal medicine, has been appointed an associate dean of the U. of I. College of Medicine. Dr. Seebohm, who is director of the Allergy Division at the U. of I. Health Center, will participate in general administration and planning for the College and will coordinate programs in clinical teaching and practice.

Dr. H. E. Rudersdorf, of Sioux City, has been certified as a diplomate of the American Board of Family Practice.

Two faculty members at the U. of I. College of Medicine were initiated recently into the Iowa Chapter of Alpha Omega Alpha (AOA), national honor medical society. They are **Dr. John W. Eckstein,** dean of the U. of I. College of Medicine, and **Dr. Adrian E. Flatt,** professor of orthopedics. **Dr. Frederic W. Stamler,** professor of pathology, is counselor of the AOA chapter, and **Dr. C. E. Radcliffe,** professor of dermatology, is secretary-treasurer.

Dr. Paul M. Kersten, who took a sabbatical from his practice of psychiatry in Fort Dodge, will return there in early September. Dr. Kersten and his family have been living on the island of Mallorca in the Mediterranean. They plan to take a two-month tour of the continent before returning to this country. Dr. Kersten has served as speaker of the IMS House of Delegates.

Dr. Johann L. Ehrenhaft, professor and chief of the Division of Thoracic Surgery at the U. of. I. College of Medicine, recently lectured on "Coronary Disease," at the Eastern Maine Medical Center in Bangor, Maine.

Dr. Kirk H. Strong, of Fairfield, who has discussed drugs at meetings of several civic organizations in the southwest Iowa area, recently testified at a drug abuse hearing in Washington, D. C.

Dr. William E. Connor, professor and director of the Clinical Research Center at the U. of I., reported recently on "The Control Mechanisms of Cholesterol Metabolism in the Plasma and Tissues," at the Bowman Gray School of Medicine in Winston-Salem, North Carolina.

Dr. F. Darwin Zahn has joined Medical Associates in Dubuque in the practice of general surgery.

Dr. James H. Habermann, a Fort Dodge pathologist, was guest speaker at the June meeting of the Wright County Medical Society in Clarion. Dr. Habermann spoke on exzyme and other laboratory aids in the practical diagnosis of myocardial infarctions.

Dr. Francois M. Abboud, professor of internal medicine at the U. of I. College of Medicine, has been elected president-elect of the American Federation for Clinical Research.

Dr. Willis M. Fowler, professor emeritus in the U. of I. Department of Internal Medicine, has been honored by the American College of Physicians (ACP) by being elected a Master, highest membership category in the 16,000-member international medical society. A U. of I. faculty mem-

ber since 1929, Dr. Fowler is a past vice-president of ACP. He has written more than 65 published scientific articles and is the author of the book, HEMATOLOGY.

Dr. Charles A. White, an associate professor in the Department of Obstetrics and Gynecology at the U. of I. College of Medicine, was a guest speaker at two recent medical meetings. Dr. White spoke on "High Risk Obstetrics" at a meeting of the Henry County Medical Society, and he presented a paper on "Recognition and Management of High Risk Obstetrical Patient and Her Infant" at a meeting of the Buena Vista County hospital staff.

Dr. Jesse Walker, of Newton, and **Dr. Richard Utne,** of Mason City, both participated in the Iowa Farm Bureau Women's Summer Conference. Dr. Walker gave a presentation on noise and how it affects loss of hearing. Dr. Utne described his service aboard the S.S. Hope in Nicaragua.

Dr. Robert T. Soper, professor of surgery at the U. of I. College of Medicine, gave three presentations at a June pediatrics postgraduate seminar held at Children's Memorial Hospital in Omaha. Titles of his talks were "Hirschsprung's Disease in Infancy and Childhood," "The Place of Parental Feeding in Surgical Problems of Infancy and Childhood," and "Congenital Gastrointestinal Tract Obstruction."

Dr. John A. Gius, professor of surgery at the U. of I. College of Medicine, presented a paper on "Lip Capillaries in Cigarette Smokers with Lung Disease and Peptic Ulcer," at the sixth conference of the European Society for Microcirculation held in Aalborg, Denmark, in June.

A volunteer medical relief team, IMT (International Mercy Team, a Mason City emergency relief organization), founded by **Drs. Richard Utne** and **Glenn Haydon,** of Mason City, has been authorized by the U. S. State Department to set up headquarters in Peru to aid those injured in the devastating earthquake which killed 30,000 and left thousands more homeless.

Under sponsorship of the Woodbury County Medical Society, **Dr. George Spellman,** of Sioux City, addressed a spring meeting of the local Rotary Club on the state of health care in that community. Dr. Spellman provided statistical data on the scope of medical services in Sioux City, e.g., there are 7.4 hospital beds per thousand people; there are 108 medical doctors; there are 2,300 persons employed in Sioux City in the health care field. Dr. Spellman highlighted recent developments and mentioned the community's kidney dialysis equipment, the coronary care capability, the mental health center, etc. He referred to the $14 million sum being expended for various new construction and renovation projects in the health field in Sioux City.

Dr. Hans Zellweger, professor of pediatrics at the U. of I. College of Medicine, was a guest speaker at the July meeting of the German Society for Human Genetics and Anthropology at the University of Kiel, Germany. Dr. Zellweger lectured on "Prenatal Chromosome Analysis and Prenatal Sex Identification" and "Non-Mongoloid Trisomy G." He also presided at a special session on "Autosomal Cytogenetics."

Deaths

Dr. Malcolm A. Royal, 88, longtime Des Moines physician, died on Saturday, May 30, at Iowa Lutheran Hospital in Des Moines. Dr. Royal received his M.D. degree from the U. of I. College of Medicine in 1906. He had served on the board of the Iowa State Medical Examiners and was a past president of the Polk County Medical Society.

Dr. Elmer B. Mountain, 88, former president and chairman of the board of American Mutual Life Insurance Company, died of emphysema on Tuesday, June 9, at his home in Des Moines. A native of West Liberty, Dr. Mountain received his medical degree from Drake University where he taught for three years after graduation before entering into private practice. In May of this year, Dr. Mountain, his wife, Jean, and his son, Dr. George E. Mountain, were honored as the first "Distinguished Drake Family," by the University's Alumni Association.

Dr. Wayne A. Johnston, 80, died Friday, July 3, when the station wagon he was driving went off a county road and crashed into a tree. Dr. Johnston, who co-founded Medical Associates in 1924, had been retired 10 years. A graduate of the University of Michigan School of Medicine, Dr. Johnston was a member of Dubuque's Elks and Rotary Clubs, American Legion, past president of the Boys Club and Chamber of Commerce, and past director of the United Fund campaign. He was also a member of the American College of Radiology and the American Institute of Pathology.

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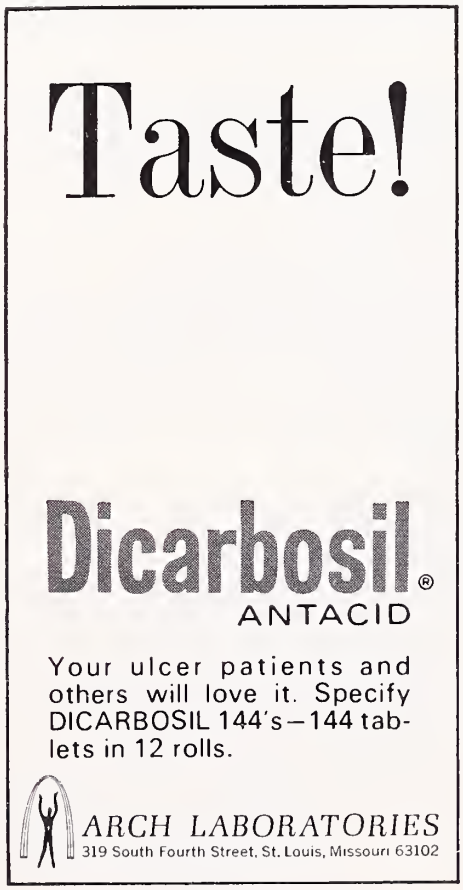
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Index to Advertisers

Arch Laboratories 605

Becton, Dickinson and Company 554A, B
Bristol Laboratories 607
Burroughs-Wellcome & Co. 576D

Campbell Soup Company 576A
Carlton Corp. 553
Casualty Indemnity Exchange 546

Dow Chemical Company 590A

Hynson, Westcott & Dunning, Inc. 547

Lederle Laboratories 549
Lilly, Eli, & Company 545, 558

Medical Protective Company 586

National Drug Company 570A, B, 598A, B

Poythress, Wm. P., & Company 590B
Prouty Company 599

Roche Laboratories 608

Searle, G. D., & Company 576B, C
Seven-Up Bottlers of Iowa 606
Schering Laboratories 562A, B
Smith, Kline & French Laboratories 554

Tobacco Institute 550-551

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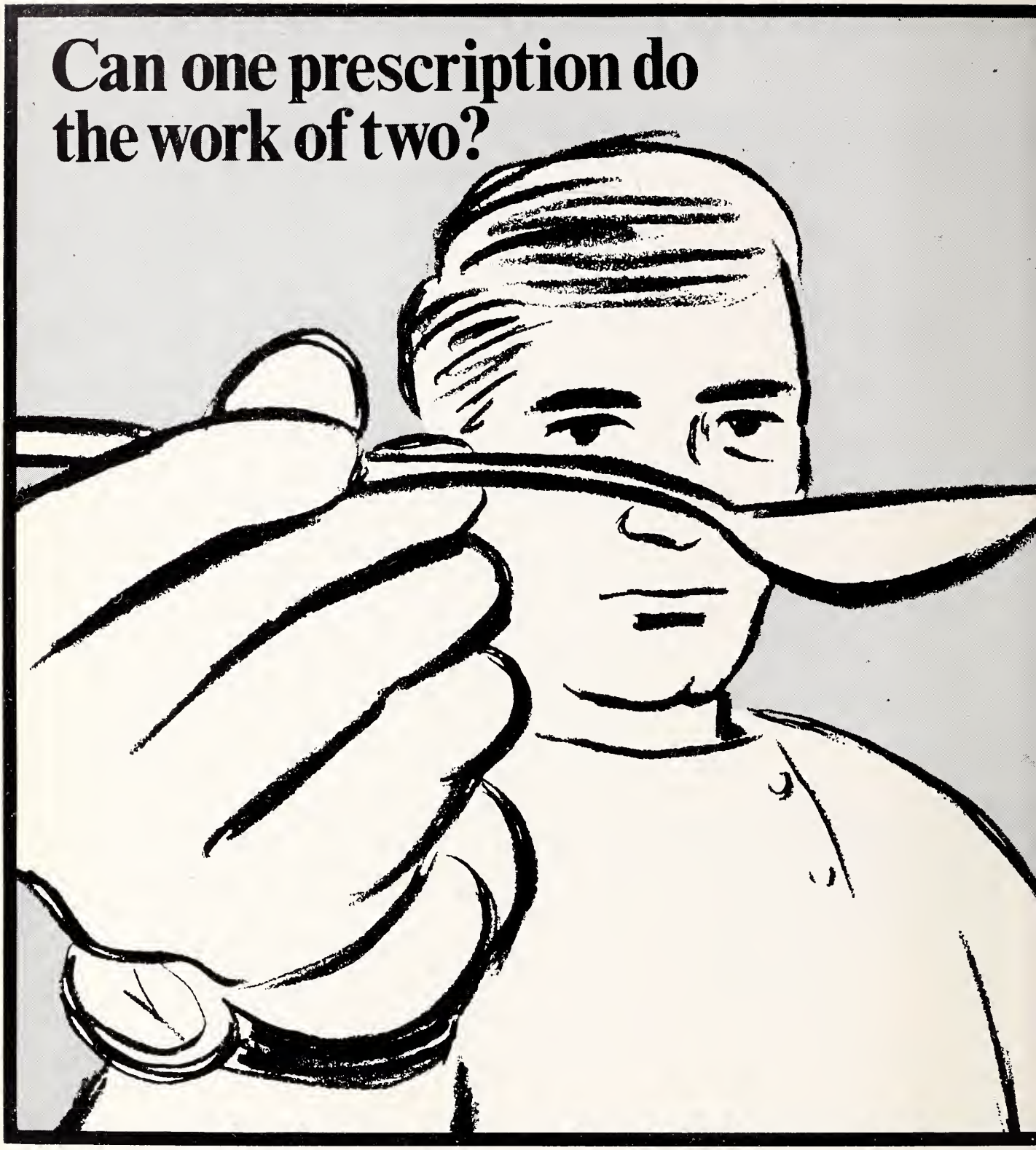
IN THIS ISSUE

- The Physician, Marihuana and Reason—A. S. Norris, M.D.
- Continuous Suction Therapy of Pneumothorax in Newborn Infant: A Rapid, Cribside Technique—James W. Hopkins, M.D., and Charlotte Fisk, M.D.
- Reproductive Factors Associated With Radiotherapy of Malignant Lymphomas—Donna L. Sooby, Ph.D., Herbert L. Jackson, Ph.D., and A. Curtis Hass, M.D.
- Highlights of Executive Council Meeting



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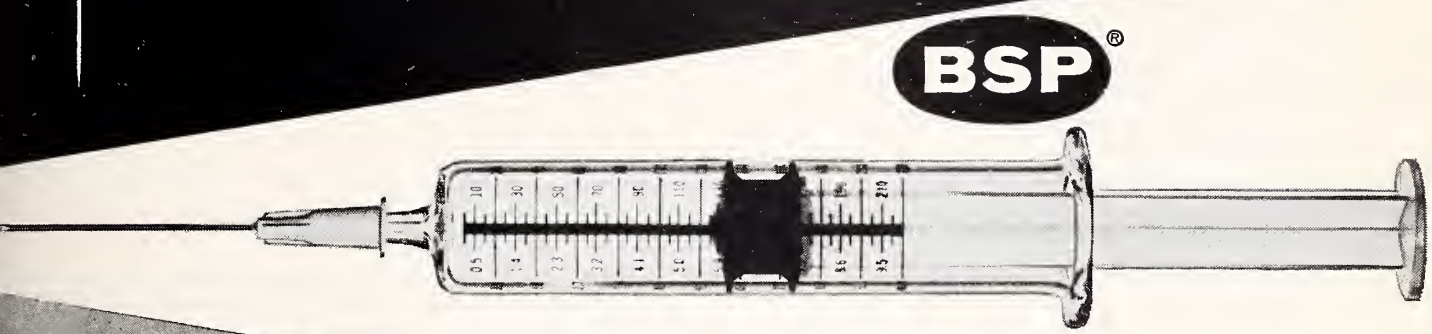
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CONTENTS

SCIENTIFIC ARTICLES

The Physician, Marihuana and Reason
A. S. Norris, M.D. 623

Continuous Suction Therapy of Pneumothorax in Newborn Infant: A Rapid, Cribside Technique
James W. Hopkins, M.D., and Charlotte Fisk, M.D. 631

Reproductive Factors Associated With Radiotherapy of Malignant Lymphomas
Donna L. Sooby, Ph.D., Herbert L. Jackson, Ph.D., and A. Curtis Hass, M.D. 636

EDITORIALS

Extracranial Arterial Disease 641

Parents & Teenagers 642

The Proctoscopic Exam 643

SPECIAL DEPARTMENTS

Coming Meetings 616

Month in Washington 618

President's Page 640

Information from Iowa Heart Association: Angiocardiography
Manuel Viamonte, Jr., M.D., Frank J. Hildner, M.D., and Carl E. Fabian, M.D. 644

State Department of Health 646

Doctor's Business 648

American Association of Medical Assistants . . . 651

Woman's Auxiliary News 652

Personals 657

Deaths 662

In the Public Interest Facing page 670

MISCELLANEOUS

Named Assistant Deans 639

Medicare-Medicaid Pay 69% 645

Council Evaluates Foundation Concept 656

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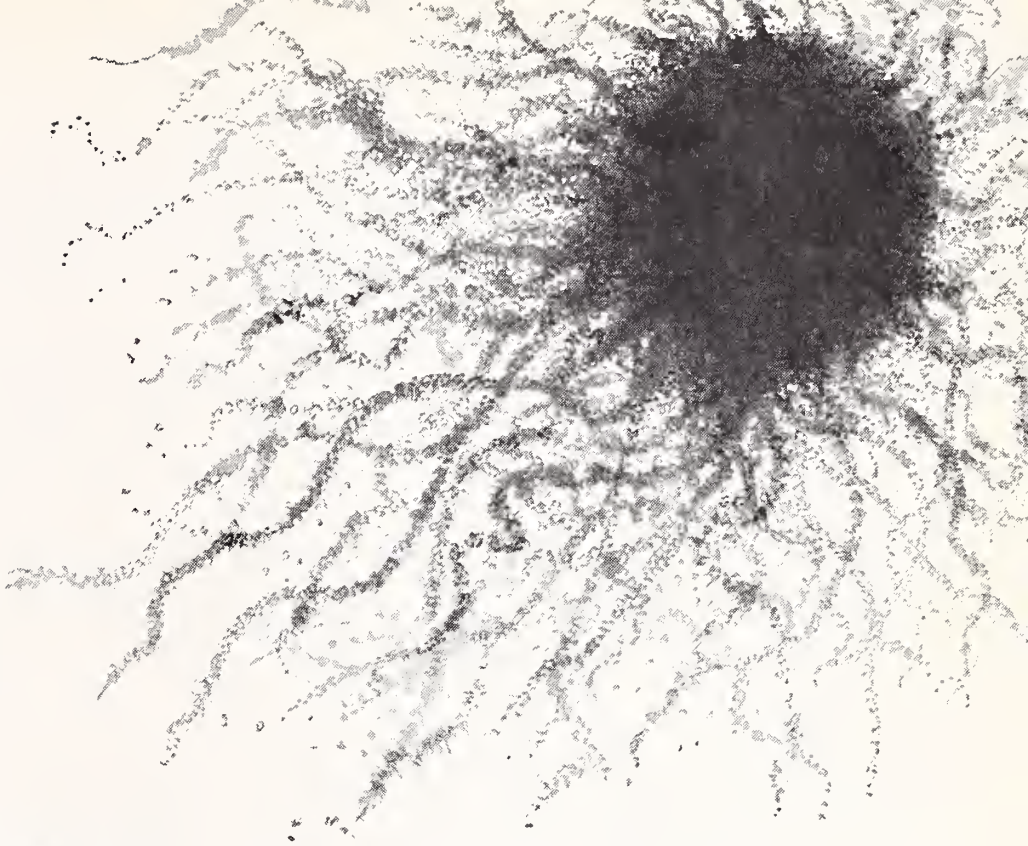
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Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

COMING MEETINGS

IN STATE

Sept. 18-19	**17th Annual Symposium on Arthritis sponsored by Section of Internal Medicine, Iowa Methodist Hospital and Iowa Chapter Arthritis Foundation,** Jester Auditorium, Iowa Methodist Hospital, Des Moines.

CONTINENTAL U. S.

Sept. 1-4	**Wyoming State Medical Society,** Jackson Lake Lodge, Moran.
Sept. 9-11	**Postgraduate Course on Renal Diseases: Pathophysiology, Diagnosis and Management sponsored by American College of Physicians,** Mayo Clinic, Rochester.
Sept. 10-12	**American Association of Obstetricians and Gynecologists,** Homestead, Hot Springs, Virginia.
Sept. 11-19	**American Society of Clinical Pathologists,** Marriott Motor Hotel, Atlanta.
Sept. 14-16	**Postgraduate Course on Current Practice of Clinical Electroencephalography sponsored by American Electrocneephalographic Society,** Washington, D. C.
Sept. 14-18	**Postgraduate Course on Advances in Internal Medicine,** University of California San Francisco Medical Center, San Francisco.
Sept. 17-19	**Annual Meeting of American Electroencephalographic Society,** Shoreham Hotel, Washington, D. C.
Sept. 18-19	**Symposium on Myocardial Infarction co-sponsored by Minnesota Heart Association and Northlands Regional Medical Program.** Methodist Hospital, St. Louis.
Sept. 19-20	**American Association of Ophthalmology,** Las Vegas.
Sept. 19-20	**Third National Congress on Medical Ethics,** Ambassador West Hotel, Chicago.
Sept. 19-25	**Annual Otolaryngologic Assembly of 1970,** University of Illinois Medical Center, Chicago.
Sept. 20-24	**Michigan State Medical Society,** Pantlind Hotel, Grand Rapids.
Sept. 21-25	**Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta.
Sept. 23	**Symposium on Surgery and Coronary Artery —An Evaluation sponsored by Adolf Gundersen Medical Foundation and Wisconsin Heart Association,** Wisconsin State University, LaCrosse.
Sept. 23-26	**Annual Meeting, Colorado Medical Society,** Broadmoor Hotel, Colorado Springs.
Sept. 24-26	**Central Association of Obstetricians and Gynecologists,** Drake Hotel, Chicago.
Sept. 25-Oct. 1	**American Academy of General Practice,** San Francisco.
Sept. 28-30	**Association of Life Insurance Medical Directors of America,** Statler Hilton Hotel, Boston.
Sept. 28-Oct. 2	**Hospital Medical Staff Conference sponsored by University of Colorado School of Medicine,** Denver.
Sept. 29-Oct. 2	**American Roentgen Ray Society,** Deauville Hotel, Miami Beach.
Sept. 30	**First Nationwide Private Doctors Institute (Financial, Legal and Economic Factors Affecting Private Doctors), sponsored by Association of American Physicians & Surgeons,** Richmond, Virginia.
Sept. 30-Oct. 1	**30th Congress on Occupational Health sponsored by American Medical Association,** Century Plaza Hotel, Los Angeles.
Oct. 1-2	**Sixteenth Annual Symposium on School Health, sponsored by University of Kansas School of Medicine,** University of Kansas Medical Center, Kansas City, Kansas.
Oct. 2-3	**Cardiovascular Symposium sponsored by Great Plains Heart Association in co-operation with St. Louis Heart Association and AHA Council on Clinical Cardiology,** Stouffer's Riverfront Inn, St. Louis.
Oct. 4-9	**American Society of Plastic and Reconstructive Surgeons,** Century Plaza Hotel, Los Angeles.
Oct. 5	**Postgraduate Course on Medical Technology,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.
Oct. 5	**Annual Meeting of American Academy of Ophthalmology and Otolaryngology,** Dunes Hotel, Las Vegas.
Oct. 5-7	**Three Days of Cardiology presented by American Heart Association Council on Clinical Cardiology in cooperation with Chicago Heart Association,** Passavant Memorial Hospital, Chicago.
Oct. 5-7	**Tenth Air Pollution Medical Research Conference,** Roosevelt Hotel, New Orleans.
Oct. 5-9	**Postgraduate Course on Basic Mechanisms in Internal Medicine sponsored by American College of Physicians,** Medical College of Virginia, Richmond.

Continuing Education Courses & Conferences

Please call or write Office of Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-4792.

Sept. 9 & 10	Pediatrics Postgraduate Conference
Sept. 15 & 16	Urology Postgraduate Conference
Sept. 16	Making Nutrition a Household Word
Sept. 25 & 26	Dermatology for the Dermatologist
Sept. 25 & 26	Manipulation (Physical Therapy)
Sept. 30	Refresher Course on Cerebrovascular Disease
Oct. 5-8	Intensive Coronary Care Management Course
Oct. 9 & 10	Care of Musculo-Skeletal Injuries
Oct. 14 - Apr. 28, 1971	Postgraduate Course in Psychiatry for General Practitioners and Other Physicians (meets weekly)

U. of I. College of Medicine

Oct. 5-9	**Postgraduate Course on High Risk Infant Care sponsored by University of Colorado School of Medicine,** Denver.
Oct. 8-10	**American Association for Surgery of Trauma,** Drake Hotel, Chicago.
Oct. 11-12	**Postgraduate Course on How to Detect "Black Lung" Disease sponsored by American College of Radiology,** Chase Park-Plaza Hotel, St. Louis.
Oct. 12	**Oral Cancer Seminar sponsored by University of Colorado School of Medicine,** Denver.
Oct. 12-15	**Annual Meeting Indiana State Medical Association,** South Bend.
Oct. 12-16	**56th Annual Clinical Congress, American College of Surgeons,** Conrad Hilton Hotel, Chicago.
Oct. 12-16	**Intervicwing, Data Gathering and Record Systems for the 1970's sponsored by American College of Physicians,** Michigan State University College of Human Medicine, East Lansing.
Oct. 17-21	**Annual Meeting American Society of Anesthesiologists,** Americana Hotel, New York.
Oct. 17-22	**39th Annual Meeting American Academy of Pediatrics,** San Francisco Hilton, San Francisco.
Oct. 18-23	**Second Scientific Assembly of American College of Emergency Physicians,** Las Vegas.
Oct. 20-23	**Neurological Aspects of Internal Medicine,** Duke University Medical Center, Durham, North Carolina.
Oct. 21-23	**17th Western Cardiac Conference sponsored by Colorado Heart Association,** University of Colorado Medical Center, Denver.
Oct. 22-24	**Annual Fall Clinical Conference, Kansas City Southwest Clinical Society,** Hotel Muehlebach, Kansas City, Missouri.
Oct. 22-24	**National Congress on Health Manpower,** Palmer House, Chicago.
Oct. 25-29	**Second Annual Fall Scientific Assembly, American College of Chest Physicians,** Century Plaza Hotel, Los Angeles.
Oct. 26-28	**New Concepts in Basic and Applied Hematology sponsored by American College of Physicians,** Jefferson Medical College, Philadelphia.
Oct. 26-29	**Medical Audit and Continuing Education sponsored by University of Colorado School of Medicine,** Denver.
Oct. 26-30	**Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta, Georgia.
Oct. 27-30	**23rd Annual Meeting American Association of Blood Banks,** San Francisco Hilton, San Francisco.
Oct. 27-31	**Congress of Neurological Surgeons,** Chase Park-Plaza, St. Louis.
Oct. 29-31	**Postgraduate Course on Gastroenterology sponsored by American College of Gastroenterology,** Statler Hilton, New York.
Oct. 30-31	**Second Annual Birth Defects Symposium sponsored by University of Florida College of Medicine,** Gainesville.
Oct. 29-Nov. 2	**Annual Meeting, Association of American Medical Colleges,** Hotel Biltmore, Los Angeles.

ABROAD

Sept. 6-12	**World Congress of Cardiology (6th),** London.
Oct. 5-7	**Postgraduate Course on Recent Advances in Gastroenterology,** Institute National de Nutrition, Mexico.
Oct. 18-Nov. 12	**Eleventh International Congress of Internal Medicine sponsored by American College of Physicians,** New Delhi.

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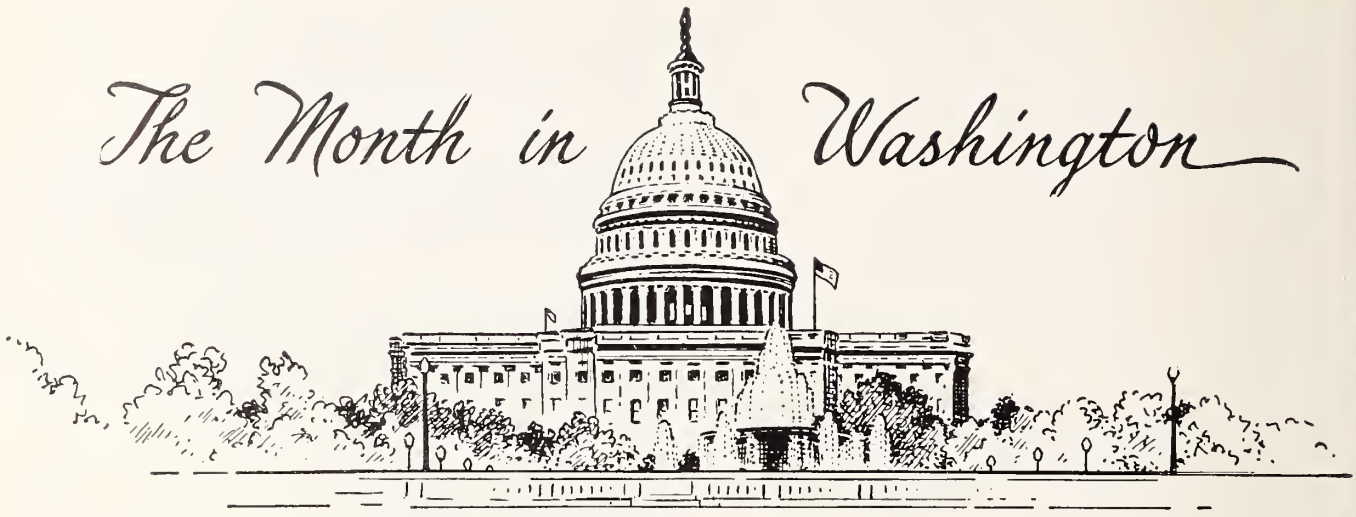
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The Month in Washington



Washington—A Democratic and a Republican member of the House Ways and Means joined to introduce the American Medical Association's Medicredit plan for federally subsidized national insurance.

The co-sponsors of the legislation (H.R. 14567) were Reps. Richard Fulton (D., Tenn.) and Joel T. Broyhill (R., Va.). Both are members of the House Ways and Means Committee which has jurisdiction over such legislation. Soon after introduction of the Fulton-Broyhill measure, Rep. Omar Burleson (D., Tex.), also a member of the Ways and Means Committee, and Rep. John Jarman (D., Okla.), chairman of the House Commerce Subcommittee on Health, introduced an identical bill. Other members of the House from both major political parties indicated they also would become co-sponsors.

Fulton, who 18 months ago introduced legislation based on the Medicredit principles for financing private health insurance for individuals told the House that the new bill "represents . . . a vast improvement over its predecessor by reason of the fact that it encompasses a built-in mechanism for the cost control." He referred to mandatory peer review.

Speaking for himself and the measure's co-author, Rep. Joel T. Broyhill (R., Va.), Fulton said the time for national health insurance has come.

"And whether we're talking about the Rockefeller approach, the AFL-CIO approach, the Kennedy approach, or the approach taken by the Committee of 100, all of them advocate sweeping changes in our health care system," Fulton said.

"An across-the-board national health insurance plan, operated regardless of need, will carry a price tag of sobering size. And no such plan I have yet seen includes—at least to my satisfaction—a mechanism which promises effective cost control of the taxpayers' money.

"This brings us to an essential element of Medicredit—its provision of peer review. This bill calls for a constant and unremitting policing mechanism.

The other two parts of the Medicredit legislation would provide for the federal government financing or assisting in the financing of medical and hospital care for individuals and their dependents through participation in the cost of insurance policies of their choice—100 per cent premium payment for the low-income groups, and graduated participation in the payment of premiums for other persons, based on their federal income tax liability.

Congress is not expected to take up this year proposals for national health insurance. But reaction to the AMA peer review plan has been highly encouraging, and prospects appeared good that Congress would approve such a plan this year for Medicare and Medicaid. Sen. Wallace F. Bennett (R., Utah), a Senate Finance Committee member, directed the Committee's staff to work with AMA staff representatives in drafting such legislation as an amendment to a bill revising Medicare and Medicaid.

In a speech on the Senate floor, Bennett said there is deep concern over the high costs of Medicare and Medicaid. He complimented the AMA on advancing peer review as a means of curbing these costs. He said:

"I believe the American people are justifiably concerned over the tremendous costs of health care. Much of that concern, it seems to me, is a product of a very real feeling that we are not getting what we are paying for. I believe, equally, that much of the apprehension, anxiety and suspicion now prevalent—for better or worse—with respect to those responsible for health care would disappear if professional standards review organizations were established and functioned effectively. It seems to me that the American people are entitled to know that American medicine shares their concern—and more importantly—proposes to do something substantial about it through means of professional standards review organizations.

I believe that physicians, properly organized and with a proper mandate, are capable of conducting an ongoing effective review program

which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions. If medicine accepts this role and fulfills its responsibility, then the Government would not need to devote its energies and resources to this area of concern. Make no mistake; the direction of House-passed social security bill is toward more—not less—review of the need for and quality of health care. I believe my amendment would provide the necessary means by which organized medicine could assume responsibility for that review."

Bennett said that, under his amendment, review groups would have responsibility for reviewing "the totality of care provided patients—including all institutional care." That responsibility he said, would be lodged, "wherever possible and wherever feasible," at the local community level. He said:

"Local emphasis is necessary because the practice of medicine may vary, within reasonable limits, from area to area, and local review assures greater familiarity with the physicians involved and ready access to necessary data. Priority should be given to arrangements with local medical societies—of suitable size—which are willing and capable of undertaking comprehensive professional standards review. . . .

"Under the amendment, the Secretary (of Health, Education and Welfare) could use state or local health departments or employ other suitable means of undertaking professional standards review only where the medical societies were unwilling or unable to do the necessary work, or where their efforts were only pro forma or token. Let me emphasize as strongly as possible that the thrust of this proposal is to have physicians, as a group, evaluate physicians and the services they provide and order as individuals."

Bennett said that the review committees should determine that only medically necessary services are provided by physicians, hospitals, nursing homes and pharmacies, and that these services meet proper professional standards.

Disciplinary measures, he said, would be in proportion to the offense and could include: 1) monetary penalties, 2) suspension from federal programs, 3) exclusion from federal programs, 4) civil or criminal prosecution, and 5) steps leading to the suspension or revocation of professional licensure.

Concerning the peer review part of his bill—H.R. 18567, "Health Insurance Assistance Act of 1970"—Fulton said:

"The appropriate medical societies would be charged with establishing a peer review mechanism that would, among other things, review individual charges and services, wherever performed; review hospital and skilled nursing home admissions; review the length of stays in hospitals and skilled nursing homes; and review the need for professional services provided in the institution.

"The process of ongoing review can have nothing but a salutary effect on the providers of services, thereby cutting down on the occasional or unintentional abuses that would otherwise occur.

"Patterns of abuse would be detected, and the abusers either suspended from or excluded from the program. Exclusion could follow action by the Secretary of Health, Education and Welfare upon the recommendation of the peer review committee.

"In the case of fraud, or other clear intentional misconduct, the peer review committee would be expected to bring charges before the appropriate licensing body.

"And in the event that a peer review committee was *not* established by the medical society within a reasonable time, or if established was not functioning, the Secretary of HEW, in consultation with the medical society, would be empowered to appoint a peer review committee that would function."

The Fulton-Broyhill bill would provide that an individual having a tax liability of $300 or less in a base year be entitled to a certificate acceptable by carriers for health care insurance for himself and his dependents. Insurance purchased with such a full-pay certificate would require no beneficiary participation in health care charges. Federal contribution to insurance purchased by individuals under this part of the program would be scaled in favor of low-income taxpayers—from 98 per cent if the taxpayer's base year income tax is between $301 and $325, to 10 per cent when his tax liability exceeds $1,300. Basic benefits in a 12-month policy period would include 60 days of inpatient hospital care. To encourage utilization of less expensive facilities, two days in an extended care facility would count as one day of the 60 days allowed. Other basic benefits would include emergency and outpatient services, and all medical services provided by a doctor of medicine or osteopathy.

A supplemental coverage could provide, in addition, one or more of the following: prescription drugs not otherwise covered, additional days of inpatient and extended care services, blood in excess of three pints, personal health services when furnished on written direction of a physician, diagnostic and therapeutic services, and catastrophic coverage of all hospital and medical costs, up to $25,000, after the first $300 of incurred expenses borne by the beneficiary.

* * *

The Federal Communications Commission approved an application for local medical societies to operate special emergency radio services for their members.

The FCC said that such hookups could carry

only messages relating to the safety of life or urgent medical duties of users. Such emergency radio service must be cooperative, with members assessed pro rata shares for cost of operation, the FCC said.

Previously, individual physicians have been allowed to use emergency radio frequencies and to form groups of physicians for such hookups, but societies representing all physicians in an area have been restricted by FCC regulations.

The FCC said in its ruling:

"There is merit in the plan to use these stations on a coordinated basis with telephone answering services now operated by medical societies and to dispatch messages from central points where society records are readily available to assist in locating a physician when called. . . . The proposal gives promise of fostering the opportunities for service in remote, rural regions . . . (and) would permit the establishment of parallel systems for emergency communications which would be in existence and available for use in times of national crises."

Musculo-Skeletal Injuries Conference

A Conference on The Care of Musculo-Skeletal Injuries will be held October 9 and 10 at the Iowa Memorial Union at The University of Iowa in Iowa City. The Conference is sponsored by the Iowa State Orthopaedic Society and the Department of Orthopaedic Surgery of the College of Medicine.

Friday, October 9

8:30 a.m. REGISTRATION
9:15 a.m. FOREARM FRACTURES IN CHILDREN
Reginald R. Cooper, M.D.

10:00 a.m. ACUTE FRACTURES AROUND THE HIP
James W. Harkess, M.B., Ch.B., Professor of Orthopaedic Surgery, University of Louisville, Ky.
11:00 a.m. INTRA-ARTICULAR FRACTURES OF THE KNEE
J. Wm. Fielding, M.D., Director of Orthopaedics, New York Polyclinic Hospital, New York, N. Y.
11:45 a.m. METAPHYSEAL FRACTURES OF THE PROXIMAL TIBIA
Earl M. Mumford, M.D., Orthopaedic Surgeon, Sioux City
2:00 p.m. FRACTURES OF THE ANKLE
Richard N. Stauffer, M.D.
2:45 p.m. PRINCIPLES IN CARE OF OPEN FRACTURES
Gerald S. Laros, M.D.
3:45 p.m. INJURIES TO THE TALUS
Robert W. Wray, M.D., Orthopaedic Surgeon, Cedar Rapids
4:30 p.m. COMPLICATIONS OF PLASTER AND TRACTION
Dr. Harkess

Saturday, October 10

8:30 a.m. X-RAY QUIZ
Carl L. Gillies, M.D.
9:00 a.m. HIDDEN NECK INJURIES
Dr. Fielding
10:00 a.m. PANEL DISCUSSION OF SUBMITTED CASES

Unless otherwise noted the Conference participants are members of the U. of I. College of Medicine faculty.

Announce Family Practice Exam

The American Board of Family Practice has announced it will give its second examination for certification in various centers throughout the country. The second examination will cover a two-day period on February 27-28, 1971. Information on the examination may be obtained by writing Nicholas J. Pisacano, M.D., Secretary-Treasurer, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex No. 2, Room 229, Lexington, Kentucky 40506.

The deadline for receiving completed applications for the examinations is November 1, 1970.

INHA Appoints New Director

The Iowa Nursing Home Association has appointed Mr. H. L. Showers to serve as its executive director. A native Iowan, Mr. Showers is returning to the midwest from California where he has been manager of the industrial relations for the space division of the Aerojet General Corporation.

Mr. Showers succeeds Ralph J. Quackenbush who will be retained by the INHA as a consultant and will utilize his experience in research and the development of new programs.

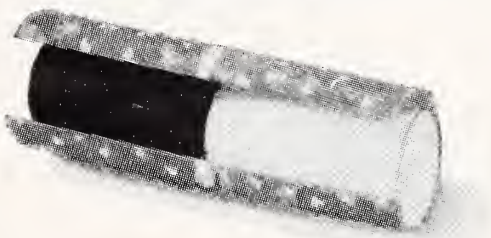
AMA Parley in Boston

The 24th Clinical Convention of the American Medical Association will be held November 29 to December 2 in Boston, Massachusetts. Some 7,500 physicians, guests, medical students, residents, nurses, other allied health professionals and industrial and scientific exhibitors are expected to attend the convention.

The scientific program is being planned by the Greater Boston medical community which includes three medical schools, more than 30 major hospitals and some 9,000 physicians. The program for the convention will be published in the October 19 issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

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Scientific Articles

The Physician, Marihuana and Reason

A. S. NORRIS, M.D.
Iowa City

"Human reason is like a drunken man on horseback; set it up on one side, and it tumbles over on the other."

MARTIN LUTHER

DURING THE 1960's the use of psychotropic or mind influencing drugs spread to large segments of the American people, particularly those of the "under thirty" generation. The phenomenon has been explained in many ways by many people and proposed solutions have been prolific, yet without consensus. There has been extensive emotional and vocal debate in all sections of our society and in all media of communication, regarding the effects of these drugs. Of all of them, marihuana is the one which is used most widely and the one around which revolves most of the current controversy.

What is marihuana and what do we know about it? Physicians have found themselves defined as experts and quite naturally many have turned to them for information and advice. Unfortunately, most physicians have available to them only the information distributed by the news media which is too frequently biased, emotional and prejudiced. The most extreme advocates of any stand tend to get the most publicity. Frequently those who use drugs have more "facts" about marihuana than do most physicians. However, statistics can be manipulated and misinterpreted, and unfortunately this has happened with marihuana.

There is a deplorable paucity of research experience with marihuana; that which does exist is often poorly done and that which is well done has often been misinterpreted.

It is difficult to overemphasize the importance of the physician knowing what is known and maintaining a calm and rational attitude toward the entire issue. He must be reasonable if he is to be an effective educator and a useful source of help for those in trouble with drugs.

WHAT IT IS

Marihuana or cannabis is a plant which grows in much of the world. The active principle is tetrahydrocannibal (THC) which comes largely from the female plant, particularly the resin on the leaves and the flowers. Various preparations are available. In the United States marihuana is usually smoked but it can be eaten in the form of candy, drunk in an alcoholic tincture, sniffed and even injected into a vein. The potency of marihuana depends upon where the plant is grown, the type of plant, the method of cultivation and the part of the plant which is used. The most common form available in the United States is "grass" which is composed of female and male plants mixed with ordinary leafy material. Acapulco Gold is a

Dr. Norris is a professor in the Department of Psychiatry at U. of I. College of Medicine.

more potent type from Mexico while hashish is the most potent form and comes from the Far East. The use of the more potent types is increasing in the United States. Marihuana tends to be unstable and changes during the growth of the plant and during processing which helps to contribute to unpredictable responses. In 1965, tetrahydrocannibanal was successfully synthesized and this provides us with an effective standardized tool for the investigation of its action.[14]

EFFECTS OF MARIHUANA

Marihuana is used because it has pleasurable effects. It usually produces a dreamy state in which ideas and images flow easily. There is a pleasant feeling of euphoria; the senses are very acute—sounds are sharper and colors are more vivid. Time may seem slowed. Usually the participant is quite happy, quite talkative and laughs a great deal, particularly when the drug is taken in a social context. Occasionally there may be mood swings and depression may intervene. Anxiety is frequently present and at times it may proceed to panic. In larger doses, marihuana effects begin to resemble those of the hallucinogens, such as lysergic acid. Then there are feelings of unreality, marked visual and temporal distortions with vivid illusions and hallucinations.[6, 9]

The psychological reactions depend upon the personality of the user, his emotional state and his physical state at the time that he takes the drug, the potency of the substance he is using and the social circumstances accompanying its use. The effects on one occasion might be quite different than on another because of the variation in one or more of the above circumstances.

The physiological effects of marihuana are also variable. The most common findings are a dilatation of the conjunctival blood vessels, an increase in blood pressure, dry mouth, ataxia and an increase in the heart rate.[18] There is no effect on respiration and the commonly believed drop in blood sugar levels does not appear to occur. None of the physical symptoms are diagnostic of its use.

HISTORY

Marihuana has been known since antiquity. The Chinese used it as an anesthetic 2,000 years ago. It is referred to intermittently in various medical texts and is occasionally mentioned as part of a religious ceremony.

It became known in America in the nineteenth century. It was used by physicians, particularly in the treatment of mental illness and childbirth but it never gained wide acceptance.

The British became concerned about its use in India and in 1893 convened the Indian Hemp Commission which produced a voluminous report in which are expressed all shades of opinion. Some felt that hemp or marihuana was responsible for a large part of the mental illness seen in Indian hospitals. Others felt that in moderate use it was not harmful. Although the results of the Indian Hemp Commission are often used to testify to the safety of marihuana, the testimony was contradictory and all of it was of an anecdotal nature which we have learned to suspect as a source of scientific information.

It was not until the 1930's that marihuana assumed great social importance, or at least became widely known in America. An intensive scare campaign associating it with murder, insanity, sex perversion and many other crimes culminated in the Marihuana Tax Act of 1937. This act levied a tax of one dollar on dealers, buyers and physicians. Nominally the physician could continue to prescribe it but its use was so circumscribed with rules and regulations that he stopped doing so. The market for marihuana as a medication disappeared, its legal production stopped and marihuana became unavailable for any legitimate use, including that of research. Illegal marihuana traffic continued.

In the early 1960's lysergic acid diethylamide (L.S.D.-25), a psychotomimetic drug which produces distortions of reality and feelings of cosmic awareness, introduced the whole "drug scene." There were those who saw in L.S.D.-25 a solution to all the problems of mankind. Its safety was emphasized and there was a movement for its legalization. Its use grew rapidly until research demonstrated the possibility that L.S.D.-25 produced chromosome damage.[18] Following this demonstration there was a rapid retreat from L.S.D. toward marihuana. The use of marihuana has grown rapidly, particularly in the colleges and more recently in the high schools. There is almost no way to know how many have used marihuana but estimates are

that 5 to 20 million people in the United States have at least experimented with it. Surveys in the schools show from 6 per cent experience to as much as 80 per cent. On a world wide basis estimates are that 250 million to 400 million people have used marihuana.

SOLUTIONS AND ATTITUDES

Those who see marihuana use as a great problem and those who see it as harmless and perhaps even a boon to mankind will agree that this is a social issue, although their solutions may be different.

The kinds of solutions we propose for social problems are a reflection of our attitudes and unfortunately attitudes are not always a reflection of information. This is clearly shown with marihuana.

The attitudes toward the use of this drug became polarized in the 1930's and remain so to this day.

An American pamphlet published in 1936 by the International Narcotics Association states "while the marihuana habit leads to physical wreckage and mental decay, its effect upon character and morality are even more devastating. The victim frequently undergoes such degeneracies that he will lie and steal without scruples. He becomes utterly untrustworthy and often drifts into the underworld where, with his degenerate companions, he commits high crimes and misdemeanors."[7]

This is in contrast with the conclusions of the first objective research ever carried out on marihuana. This was done at the instigation of Mayor LaGuardia under the auspices of the New York Academy of Medicine. They reported in 1944 the results on 77 cases and concluded that: "The practice of smoking marihuana does not lead to addiction in the medical sense of the word—the use of marihuana does not lead to morphine, heroin, or cocaine addiction and no effort is made to create a market for these narcotics by stimulating the practice of marihuana smoking. Marihuana is not the determining factor in the commission of major crimes. Juvenile delinquency is not associated with the practice of smoking . . . the publicity concerning the catastrophic effects of marihuana smoking in New York City is unfounded."[12]

More recently (1969), Dr. Keith Yonge, President of the Canadian Psychiatric Association, was quoted in a Canadian newspaper as stating "the evidence that some of the psychotropic drugs—marihuana, for example—are less harmful than others, should not detract from the conclusions that all, including marihuana, are seriously harmful by virtue of their specific action of distorting perceptual and cognitive processes of the brain." He goes on to urge that laws regarding these drugs, including marihuana, should not be more permissive and wishes consideration to be given to extending the law against "loitering" to make neglect of educational and occupational opportunities an offense and suggests the establishment of work colonies to deal with drug offenders.[16]

At almost the same time, Dr. Margaret Mead, the renowned anthropologist, told United States Senators "there should be no more restrictions on smoking marihuana than on drinking beer." She states "there is no evidence marihuana is harmful in itself or leads to the use of more dangerous substances." She goes further and says "it doesn't lead to the excesses of behavior that alcohol does" and "it does not have the toxic effects tobacco has."[13]

So these two sets of attitudes existing side by side have changed little in 25 years.

Arguments supporting ever more restrictive and punitive laws controlling the use of marihuana are based on the belief that it produces crime, leads to heroin addiction, produces mental illness and personality deterioration. Most such laws have also included restrictions which amount to a ban on research because it is "known" that marihuana can have no conceivable medical use. Also implicit in such an approach is that laws will in fact control the use of marihuana.

Those who argue as strongly for legalization do so because in their opinion it is not harmful, it has great social value, it has potential medical uses and current and proposed restrictive laws do more harm than good.

Two separate sets of such well formed, contrary opinions about the same drug either have different sources of information or ignore what is available. Perhaps there is not enough information to make a reasoned decision.

Does marihuana produce crime? Mr. Anslinger, former Commissioner of Narcotics, testified in 1937 that marihuana produced a great

deal of violence and crime, including rape and murder. In the late 1930's the Federal Bureau of Narcotics supported literature which used such statements as "marihuana is a powerful narcotic in which lurk murder, insanity and death."

By 1955, the same Mr. Anslinger stated that marihuana was not a controlling factor in the commission of crime.

A recent committee in England could find no evidence that the increased use and consumption of marihuana in Britain was causing violent crimes or aggressive anti-social behavior.[1]

Is marihuana addicting? Does its use lead to heroin addiction? In 1937 Mr. Anslinger testified that he had not heard of a case of marihuana use producing heroin addiction. He stated, "I think it is an entirely different class of drug, the marihuana addict does not go in that direction." However, by 1955, Mr. Anslinger expressed his concern that the use of marihuana over a long period of time would lead to heroin addiction. No other data is available, but the opinion changes. It is very difficult to know what the relationship is. Certainly there is a strong association at the present time between the use of the hard drugs such as amphetamines, barbiturates and heroin with the use of marihuana. They generally come from the same source. Have our present restrictive laws produced this association and would legalization of marihuana separate the drugs out and prevent the transition from marihuana to other drugs? Who can say?

Does marihuana produce mental illness?

There are several reports which describe psychotic complications of marihuana use.[10, 17] Most of these have been transient but some have been prolonged and some have been manifested by violence.

At times a patient may experience a "flash back," a phenomenon which is commonly reported with L.S.D., consisting of a recurrence of the drug experience. There is evidence that perhaps this complication is more common with marihuana than had been supposed.

The following case study represents one such instance:

A college student, age 18, smoked marihuana on three occasions. Following his first cigarette he experienced no effect. A few days later he smoked another and suddenly felt he was facing a blank, gray wall. He closed his eyes and suddenly felt he was behind the wall and was unable to get out. This produced the worst fear he had ever felt. He managed to get out of the room and the feeling passed. The third time he had a fairly pleasant experience. Some weeks later, in the presence of other people, he suddenly had feelings of panic like his second "trip." It lasted only a few minutes but he was frightened that the experience was no longer under his control and he did not smoke marihuana again. Approximately two years later the patient again experienced transient feelings of anxiety which recalled to him his second marihuana experience.

It is difficult to evaluate the effects of marihuana in patients who are hospitalized because of mental complications. They bring into the situation their own premorbid personalities. Even when cooperative, they cannot be sure the substance they used was marihuana, what dose it was or whether it was adulterated with another drug.

The first controlled study was reported by Allentuck in 1944.[12] Seventy-seven subjects received marihuana in varying concentrations. We know they received no other drug. The amount was quantified relative to each dose and to each subject, although it is not clear by current standards how much of the active principle was present. In any event, nine of the 77 subjects did develop a psychotic reaction. For the most part it was transient, lasting over a few hours and then apparently remitting completely. In three however, a definite psychotic state of longer duration developed. It is to be further noted that in naive users or first-time users 27 per cent of the subjects reported significant feelings of anxiety. Allentuck at that time indicated, "the conclusion seems warranted, that given the potential personality makeup and the right time and the environment, marihuana may bring on a true psychotic state."[12]

In 1968 Weil *et al.* examined the effects of smoking marihuana. In addition to marihuana they used a placebo cigarette made from the male cannabis plant which has no active principle. They did not observe any psychotic reactions among their 17 subjects.[19]

Why this difference in the results? These studies are difficult to compare. They were done a generation apart, the doses are not ex-

actly comparable, the subjects in Allentuck's study were from a prison, those Weil studied were volunteers.

There have been reports in which tetrahydrocannabinal, the active component of marihuana, was ingested in pure form instead of being smoked and similar psychotic pictures were observed.[6, 9] The most recent study, however, using tetrahydrocannabinal did not demonstrate any psychotic reactions.[18]

One cannot make any statements with confidence about the incidence or likelihood of mental complications with the use of marihuana. It does appear, however, that it can produce psychotic reactions, including panic states under some conditions with some people at some dose levels.

Many are convinced that if marihuana is not dangerous in more obvious ways, that its prolonged use will produce personality deterioration. They associate it with the long hair, protest movements and the leftist political leanings of the "hippie generation." It is easy to blame these problems upon a drug but very hard to prove an etiological relationship. There have always been dropouts from society, with or without drugs. Whether drugs produce even more dropouts or whether dropouts are simply now taking drugs is very difficult to ascertain. Marihuana is widely used in various parts of the world and while there is evidence of abuse wherever it is used, there are large segments of society in some countries who apparently use it in moderation. There does appear to be a relationship between heavy marihuana users in these societies and those who have dropped out of the main stream of life. Whether marihuana use is a cause or an effect cannot be answered.

Does marihuana have any medical uses? There are a number of reports of marihuana use in the literature of the nineteenth century, particularly in reference to the treatment of mental illness and childbirth. It was never widely used and certainly many more effective methods for dealing with these problems have evolved since that time. It is not known whether marihuana has any application in modern medicine. It has been unavailable during the past 30 years when the most sophisticated methods of medical research have developed. Certainly the drug has qualities and actions of which we know little and which need to be investigated. We cannot condemn the drug as having no use without knowledge. Even thalidomide which has been associated with so much horror in recent years was found to be a tremendous help in the treatment of certain types of leprosy.

CONTROL

Legal solutions are a time honored method of solving social problems. But reason demands that information exist for passing rational laws and assumes that the laws can solve the problem.

The extremely repressive laws passed at the federal and state level typified by the Marihuana Tax Act of 1937 were not a reflection of the inherent qualitives of marihuana but rather a reflection of propaganda about it. When these laws and this propaganda state an intimate and inevitable association between marihuana and crime and mental illness and when students cannot observe this association among their acquaintances a credibility gap between the generations is created. When we realize that the total of observed marihuana reactions in controlled conditions is 218* cases and when we observe the variability and the inconsistency of response, then we can see the irrationality of this kind of legal response.

Iowa law was consistent with the national trends. The first offense with marihuana was punishable by a fine of not more than $2,000 and imprisonment in a state penitentiary for not less than two nor more than five years. This included any young boy or girl who was experimenting for the first time.

The most notable result of this kind of thinking and law making was that between 1937 and 1967, only one piece of marihuana research was done and that under the sponsorship of the Mayor of New York City.[12]

In 1969 the Iowa Legislature relaxed the law regarding marihuana possession for personal use. In such an instance, the criminal would be imprisoned in the county jail for a period not to exceed 6 months or be fined an amount not to exceed $1,000 or both. Provision is made for suspended sentence and probation. Any subsequent conviction for possession will result in harsher punishment. The new law while less

* As of March, 1970.

than ideal does come closer to reflecting what little we do know of marihuana. It falls short, however, of a law based on facts because as yet the facts are minimal and in large part this has been a consequence of the laws themselves.

The other group who see a legal solution for the marihuana problem are those who would simply remove the problem by making marihuana legal. They urge such action because they "know" that the drug is safe.

They feel that marihuana is a relaxing drug and as such has social value. They suggest that it is far less harmful than tobacco and alcohol. Certainly it does produce relaxation and it is a pleasant experience for most people. Legalization might be a reasonable solution if the thesis that marihuana is not harmful were proven.

David Solomon, who edited the MARIHUANA PAPERS, is in favor of legalization. He states that "several million Americans are beginning to learn that marihuana is both pleasurable and harmless." He says "marihuana should be legalized. Science has demonstrated that the plant possesses a wide variety of therapeutic applications, and investigation has proved that its popular use is harmless to the individual and to society."[15]

Dr. Joel Fort, professor of social welfare at the University of California, says that alcohol and tobacco are more serious problems than marihuana and narcotics.[5] While Dr. Fort is all for research, he states "no amount of research will show the drug to be as dangerous as the number of agents already widely disseminated in our society." So prior to the research being done, Dr. Fort has already made up his mind.

A recent article about marihuana in the prestigious SCIENTIFIC AMERICAN is headed with the following statement, "there is considerable evidence that the drug is a comparatively mild intoxicant. Its current notoriety raises interesting questions about the motivation of those who use it and those who seek to punish them."[4] The author refers extensively to the New York Study of 1944 to bolster his reassuring point of view regarding marihuana use. He is assisted in this task by misreading and misinterpreting certain critical sections of the report. He states that "9 out of 77 subjects who were studied intensively, had a history of psychosis." They did not have a history of psychosis, but rather had a psychotic reaction following the use of marihuana in this study. He stated further, "this high rate could be attributed to the fact that all subjects were patients in hospitals or institutions." In fact, they were all from prison, they were not patients and they were not psychotic when they began the study. Nine psychotic reactions in 77 subjects or a rate of 12 per cent is hardly reason for reassurance.

Marihuana has been frequently compared favorably to alcohol and tobacco. It is suggested that marihuana would effectively replace these drugs and be safer. This is specious reasoning. It is not a question of either or. A recent study in the San Francisco area demonstrated that people who drink alcohol and smoke cigarettes are much more likely to use marihuana and there is a direct quantitative relationship.[11]

Claims have been made that marihuana is safer than alcohol in terms of its influence on driving behavior. In one such study which supports this view, a social marihuana high is compared to a state of legal drunkenness (.15%). This is comparable to eight ounces of alcohol being consumed by a 180-pound person in half an hour.[2] This, of course, is not social drinking and does not represent the normal use of alcohol. As one might anticipate the study does make marihuana look good. While the format of this study can be criticized it does have the advantage of any scientific study in that conditions and the amounts used for the comparison are clearly stated and therefore available for discussion and criticism. This is very much unlike most of the "information" that has been transmitted about marihuana during the past 40 years.

We have only to think of the experience with thalidomide to recognize the potential harm that may exist and which may be unrecognized for many years.

If alcohol were a new drug and we gave it to 100 people and noted its effect over a 24-hour period what would we see? We would observe that it produced relaxation and in most people a pleasant sensation. We would not know from our research that a disease called alcoholism could develop which would involve 5,000,000 people in the United States. This study would not show that in alcoholics, life expectancy is shortened and that one can develop cirrhosis of the liver as well as brain damage. These complications take many years to appear and

occur only in a certain proportion of those who do drink excessively.

It has been over 300 years since smoking was introduced in Europe, yet only in the past generation have we become aware of the relationship between smoking and lung cancer, heart disease and many other medical complications. What would we know about smoking if we gave 100 subjects two or three nicotine cigarettes and observed the effect over the next day?

Marihuana produces a pleasant feeling. If it is widely available, a certain percentage of people will learn to use marihuana as a solution to their problems. How many cases of cannabanism would we have in 20 years? I do not know, but I am sure there would be some. Would the physical and social effects of cannabanism be less than those of the use of tobacco and alcohol or would they be more?

We do not have enough information to justify current or proposed repressive laws which treat marihuana as though it were worse than many major crimes. What little we know does not support such drastic methods even if they were successful and they have not been.

On the other hand, what little we know does not justify those who are so complacent about the legalization of marihuana. There is a risk. No one who has reviewed or studied the subject has denied this, although some have certainly minimized it.

The adversary system may be the most effective way at arriving at just decisions in the court room; but it is a poor method of determining scientific truth. Those who lend themselves and their scientific reputations to either extreme of this issue do a disservice to humanity.

EDUCATION AND RESEARCH

Control based on ignorance will not be effective. Dr. Stanley Yolles, former director of the National Institute of Mental Health, has said "it is extremely unfortunate that the continued exaggerated emphasis on the supposed evils of marihuana smoking make it extremely difficult to tell people what the real risks of specific drugs are."

We have already seen demonstrated the possible effects of education on the consumption of drugs. When the genetic studies on L.S.D. suggested possible harmful effects this information did what no laws could do, it rapidly decreased the consumption of L.S.D. Laws cannot be effective unless there is some consensus upon their need and usefulness.

We cannot educate effectively without facts and we cannot get facts without research. There are certain questions to which we have no answers and we must admit it if we are ever to be believed.

What are the long term effects of marihuana use? What is the effect of various dose levels? What is the incidence of mental complications? Are there harmful physical effects? Does marihuana release anti-social behavior? Does it produce a deterioration of mentation and personality? What is effective treatment?

Some of the answers may come from research in progress at this time but we need more, much more.

At present we can say that under some circumstances, in some people, psychoses can develop. The most potent reason for not using marihuana is the fact that we do know so little about it. It seems highly likely that as has happened with all other drugs that as we learn more about them, their side effects and idosyncratic reactions become more evident. Another "fact" of course is the law but let us not depend on it alone.

Physicians are trained as scientists and truth should be their watchword. Before we indulge in easy moralizing and the passage of ever more restrictive and punitive laws which bar the way to knowledge let us ask honestly "what do we know and how can we help?"

Have we cried wolf so often that no one will believe us if we should learn about the real dangers in marihuana? Will anyone listen when the wolf is outside the door?

TREATMENT

While research and education offer the best hope for understanding and control in the future, marihuana use is with us now and we must be prepared to treat it and its complications.

Usually the patient who comes for help is experiencing an acute reaction. He has developed untoward, unexpected and frightening mental and emotional complications. He may be suffering from an acute confusional state with strong

feelings of anxiety. He may be depressed. He may exhibit a thought disturbance, and paranoid feelings resembling schizophrenia.

The acute reaction that occurs with marihuana is effectively treated with one of the major tranquilizers such as chlorpromazine in doses comparable to those used in the treatment of acute psychotic states. In the instance of chlorpromazine, 50 to 100 mg. by mouth every four to six hours is an appropriate dose if well tolerated. If the reaction is very severe one may wish to use the intramuscular route during the initial phase of treatment.

Whenever any drug is obtained illegally there is the added risk of the unknown. The history may not be reliable, either because the patient is defensive or because he himself cannot be sure of what he has taken, what dose it was or whether it was adulterated with some other drug.

Consequently, when possible, the first step in treating someone who is suspected of a marihuana reaction is hospitalization and observation. Even when the reaction in the office is relatively mild it is difficult to predict what may happen in a few hours.

The structured environment of a hospital along with reassurance may be sufficient to control the anxiety and the most acute symptoms. If the degree of panic is severe or if the behavior of the patient is dangerous to himself or others then treatment with tranquilizers will have to be instituted.

One must be constantly on the alert for the possibility of concomitant use of other drugs that the patient may have denied or thinks are not an important part of the history. If the patient has also been addicted to a barbiturate or heroin then the cessation of medication will produce withdrawal symptoms with their inherent dangers. A detailed history of drug intake, a clear explanation to the patient of the necessity for not withholding any information regarding medication is essential.

SUMMARY

The abuse of drugs is spreading and it appears that this trend will continue. An increasing number of patients will come to the physician for help because they have decided that they wish to discontinue drugs. In those instances where marihuana has become a substitute for problem solving, extensive counseling and perhaps referral to a psychiatrist may be necessary.

The physician must regard the patient who uses marihuana as a person with a problem which requires and deserves medical help. An appropriate intervention by the physician will often make the difference between health and sickness, life and death.

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To Discuss Abortion

A special day-long workshop will be presented in Des Moines September 17 by the Iowa Association for Medical Control of Abortion. Interested persons from throughout Iowa are invited to attend the meeting which will occur at the Y.W.C.A. building in Des Moines.

The workship will include an analysis of developments across the country by Mrs. Lee Gidding, executive director of the National Association for Repeal of Abortion Laws. There will also be a panel discussion relative to developments in Iowa. The meeting will convene at 9:00 a.m.

Continuous Suction Therapy of Pneumothorax in the Newborn Infant: A Rapid, Cribside Technique

JAMES W. HOPKINS, M.D.
CHARLOTTE FISK, M.D.
Des Moines

For many years intermittent needle aspiration has been standard treatment for symptomatic pneumothorax of the newborn infant. The problem of alveolar rupture occurs most often in the course of the respiratory distress syndrome, aspiration pneumonitis, or as a *spontaneous pneumothorax* of unknown etiology (Nichols & Hopwood, 1968; Avery, 1968; Krueger, *et al.*, 1968).[1-3] The premature infant's chest is characterized by its tiny dimensions and stiff *bronchial* type lung anatomy. These features invite both lung tear and subsequent lung leak whenever the currently standard needle aspiration is performed. This complication of lung injury in patients so treated has been recently noted by Nichols.[4] Thus, hesitancy on the part of the physician or surgeon to introduce a sharp pointed needle into the pleural space of the premature and newborn infant is proper and understandable. The indwelling plastic needle technique described here should reduce this complication. In addition, the technique should prevent delay in re-expansion as well as control recurrence.

Such a method has been developed and utilized in premature and term newborn infants at the University of Texas Medical Branch, Galveston, Texas, and at Mercy Hospital, Des Moines, Iowa. This technique utilizes underwater seal drainage with continuous suction to a modified plastic needle type of intrapleural catheter. The needle catheter functions over a 24 to 48 hour period, during which time any further leak from the pneumothorax is quickly aspirated without trauma of additional or multiple thoracenteses.

CASE REPORT

Baby R. W. was born at 36 weeks gestation and weighed 4 pounds 10 ounces at birth. Pregnancy was uncomplicated and delivery was by low forceps. The apgar score was 6. Mild respiratory distress was noted during the first 24 hours of life. Gradually severe distress developed, and roentgenological examination revealed an extensive pneumothorax developing on the left (Figure 3).

Pediatric surgical consultation was obtained, and a modified plastic needle chest tube was inserted in the left anterior second intercostal space at the mid clavicular line. There was slow, but definite re-expansion of the lung with bubbling of trapped intrapleural air through the water-seal apparatus. Immediate follow-up x-rays revealed re-expansion of the left lung (Figure 4).

A "bubble bottle" suction apparatus was then added to the system, and further small amounts of air were seen to bubble from the tube at intervals. The chest tube was found to be plugged during the night on one of the frequent visits by the attending staff. Recurrence of pneumothorax was suspected and confirmed by x-ray (Figure 5). Immediately the drainage tube was clamped, and the squeeze bulb of the I.V. apparatus located next to the plastic needle chest tube was compressed gently. Active egress of air through the water-seal-suction system was noted, with minimal amounts thereafter. After 12 hours compression of the rubber bulb no longer produced bubbling from the pleural space. Roentgenograms revealed satisfactory expansion (Figure 6). The plastic needle was removed from the chest at 36 hours post-insertion (Figure 7A and 7B). The infant's condi-

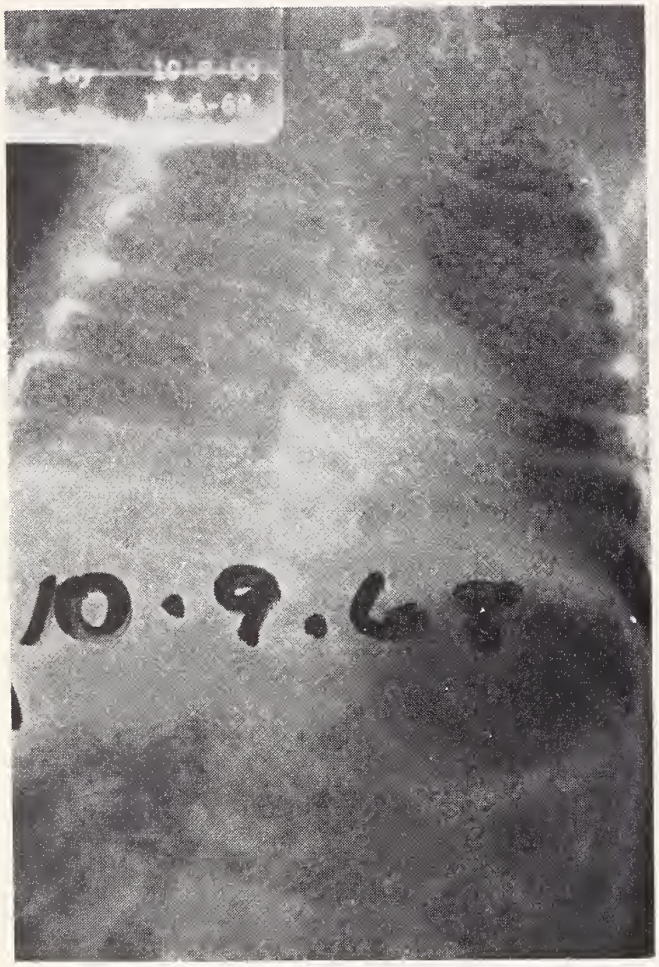


Figure 1. A.P. roentgenogram showing moderately large left tension pneumothorax. Note: Pleural line, hyperlucent left hemithorax, and shift of heart and mediastinum toward the right side.

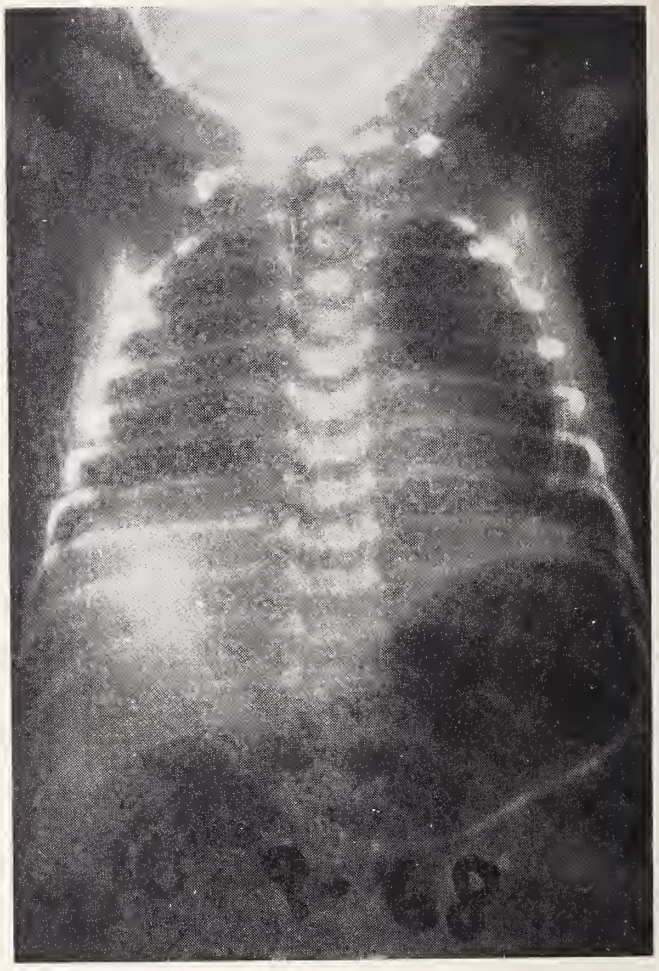


Figure 2. A.P. roentgenogram showing re-expansion of left lung immediately after insertion of perforated plastic needle via second left interspace anteriorly.

tion improved immediately after both the initial and subsequent aspirations of air. The baby's subsequent recovery and weight gain were satisfactory at follow-up at 10 months of age.

METHOD

Materials—A standard #14 plastic needle;* #11 blade; #5-0 silk (skin suture); routine prep, drape, and dressing materials (tincture of benzoin and tape utilized to stabilize the plastic needle catheter); 2 intravenous administration sets (Baxter or Cutter "plug-in" type); and two 250 cc. or 500 cc. rubber stoppered intravenous saline bottles; also, 2 additional intravenous administration sets for use with the continuous controlled suction ("bubble bottle") technique.

Technique—The 2 I.V. tubing sets are combined to make one tubing which is similar at both ends except for the tip of the end toward the bottle. This end is shortened by cutting off half of the tip (approximately 3 mm. shortened) (Figure 1). This prevents dislodgement of the "underwater seal" tube, allowing the shortened tip to extend down into the rubber top far enough to engage securely, but not far enough to displace the water-seal tubing which extends to 1 cm. under the water level. An alternate and equally satisfactory tube to bottle connection method is that of Holmes and Mark (1968) who used a standard I.V. extension tube to connect the distal end of the I.V. tubing and the water-seal bottle.[5] These authors opened the I.V. bottle and advanced the plastic "underwater-seal" tube 1-2 cm. above the rubber stopper.

The plastic needle is inserted in the second, or third anterior intercostal space taking special care to tunnel the needle for at least 1

* The "Angiocath," #14 size, was used and was found to be radiopaque; the #16 size was difficult to reopen due to kinking.

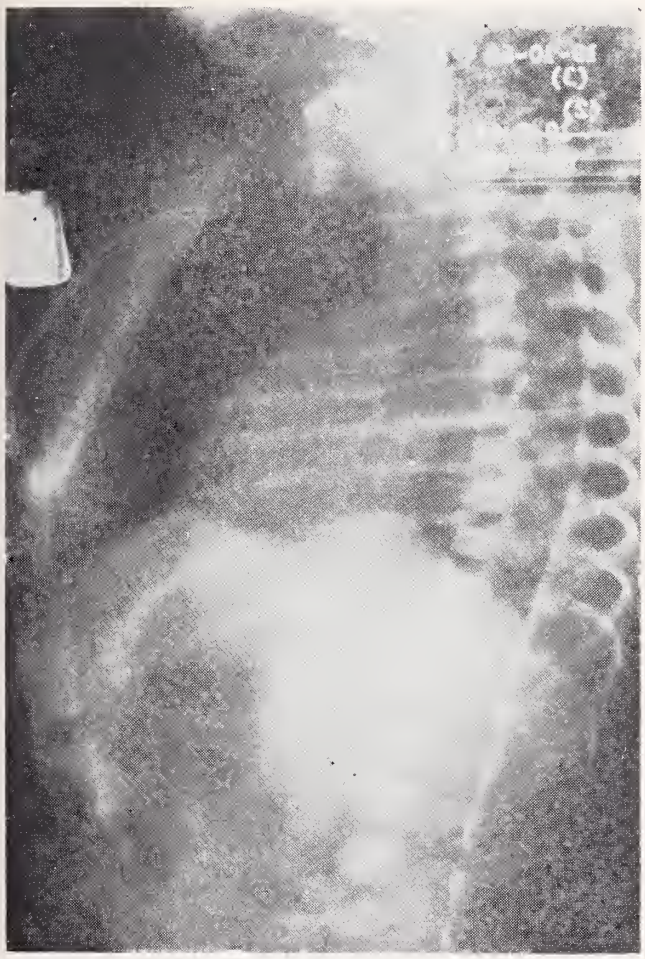


Figure 3. Left lateral roentgenogram showing recurrent left pneumothorax. Note: Air is mainly anterior with displacement of the lung posteriorly.

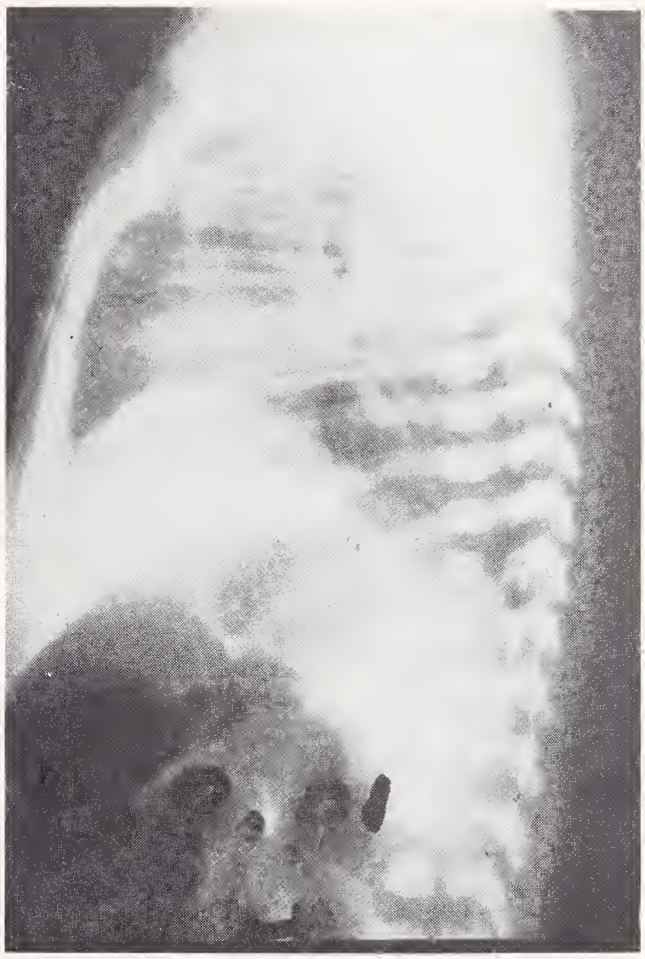


Figure 4. Satisfactory re-expansion of the left lung occurred immediately after opening of the chest catheter by compression of the "squeeze bulb" (see text).

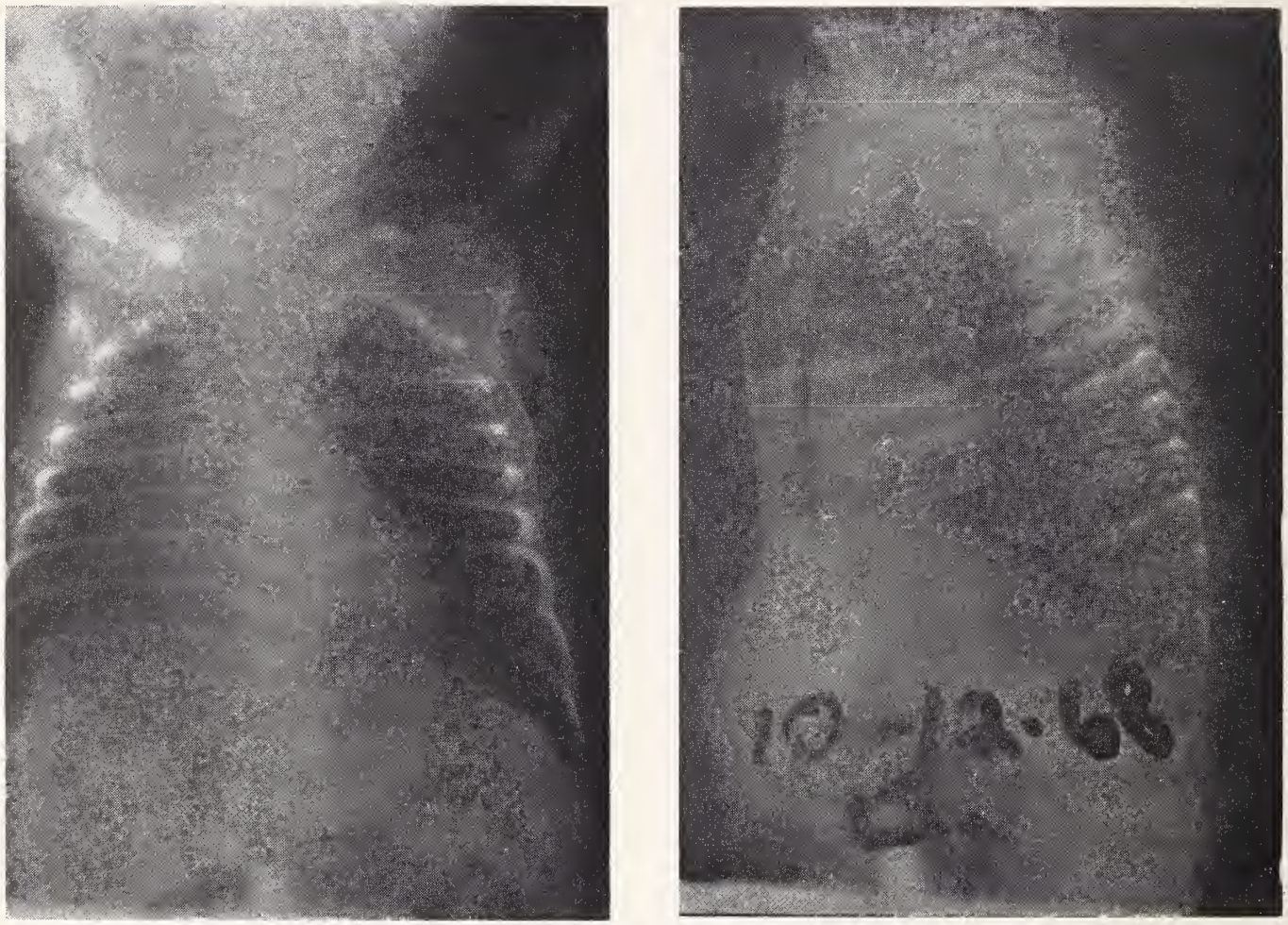
cm. under the skin. Just as the needle enters the pleural space (at right angles to the chest wall) the inner stylet is pulled out so that the sharp tip is flush with the blunt end of the plastic needle (Figure 6). The needle is then safely used as a trochar or guide for placement of the catheter into a position in the apex of the pleural space. It is important to note that two side holes are cut approximately 3 and 5 mm. respectively, from the tip of the plastic needle and nearly opposite one another using a #11 skin blade (Figure 2). This important detail has been found necessary in order to insure patency and continued function, especially if the tube should become lodged against the pleura.

DISCUSSION

The basic principle of the "Clagett's" cannula (Ellis and Carr, 1954)[8] is a blunt needle perforated with two opposing side holes for pneumothorax in older children and adults. Holmes and Mark (1968) utilized the standard "intracath" for pneumothorax.[5] Van Heerden and Laufenberg (1967) described the use of a standard plastic needle without side perforations for thoracentesis in children.[6] Our trials of the "intracath" (i.e. outer trochar) methods gave less satisfactory results and more uncertainty as regards the intrathoracic position, problems of kinking, and more frequent blockage of the tube than did the use of the perforated #14 size plastic needle (i.e. inner trochar). The perforated plastic needle technique has been used successfully at the University of Texas Medical Branch, Galveston, Texas, and recently at Mercy Hospital, Des Moines, Iowa. It has proved satisfactory and free of complications.

The method would appear to have several advantages:

1. The blunt plastic needle eliminates the danger of perforation of the lung when the visceral pleura is drawn out with re-expansion of the collapsed lung. If this technique were to



Figures 5A and 5B. AP and left lateral roentgenograms after removal of chest needle catheter showing satisfactory expansion of the left lung.

be used in an infant with a very minor or small pneumothorax, the needle theoretically could nick the visceral pleura at the initial introduction maneuver before the stylet was pulled back to the "blunt position." We have not encountered this complication, and we feel it can be completely eliminated by good judgment in using the method only in infants having symptomatic and, therefore, moderate or large sized pneumothorax, and by carefully following the described technique. Furthermore, pleural tear seems far less likely from this relatively small plastic needle stylet than with the introduction of the much larger needles required to insert the "intracath" type of plastic chest tube. The technique described must be limited to the patient having pneumothorax only. Thus, we would reserve the larger standard chest tube method for removal of fluid or blood from the pleural space. This technique has recently been reviewed by Salvor and Camarata (1969).[7]

2. Suction can be controlled. This technique provides for controlled gradual re-expansion of the lung allowing the baby to bubble out the air. If this is not entirely satisfactory or re-expansion is not complete mild suction with 6 cm. of water in the "bubble bottle" may be applied as in the case reported here. The major consideration is the phenomenon of mediastinal shift occurring when the sudden movement of the entire lung and mediastinum compromises cardiac output by compression of venous (caval) return.

3. The squeeze bulb allows for simple reopening of the tube should it become plugged, as occurred in the course of our example case. In fact, plugging has been easily corrected by this maneuver during the first 12 to 24 hours. The first 12 to 24 hours is also the period in which the greatest danger of recurrence of the pneumothorax is present. Thus, the "squeeze bulb" is a necessary and sometimes life-saving feature. It overcomes the disadvantage of the small sized tube used in this method.

4. This technique allows a simplified and more rapid placement by the feature of an inner sharp stylet made blunt after introduction into the chest cavity.

5. The materials utilized are standard and easily obtained on the ward or in the nursery where the pneumothorax occurs. Nurses and other personnel are familiar enough with this type of tubing and set-up to be instructed easily in this modification of their use. Finally, the nurses must be instructed as to the concept and care of the under-water-seal drainage. They should also be shown the technique of gently compressing the "squeeze bulb" with the distal I.V. tubing clamped off, so as to re-open the plastic needle chest tube should acute distress or apnea develop before the physician arrives.

ACKNOWLEDGEMENT

We wish to express our thanks to Dr. John R. Derrick, professor of surgery and chief of thoracic and cardiovascular surgery, University of Texas Medical Branch, Galveston, Texas, for the original stimulus to develop this technique in small infants. Also, our gratitude is due the Department of Roentgenology, Mercy Hospital, Des Moines, Iowa, for help with the x-rays in the example case discussed.

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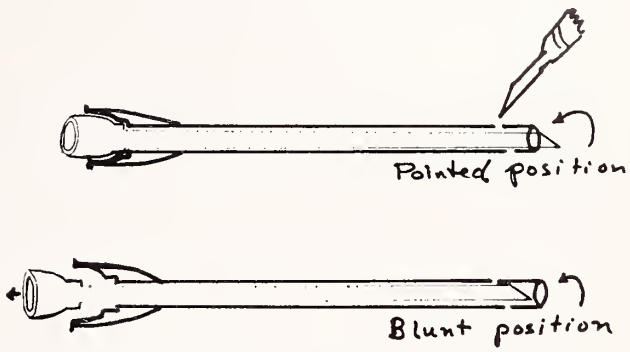


Figure 6. Preparation of perforated plastic needle. a) Note: 2 side holes cut with inner stylet in place. b) Stylet pulled to "blunt position." Length determined by measurement at the hub end of needle prior to insertion into pleural space.

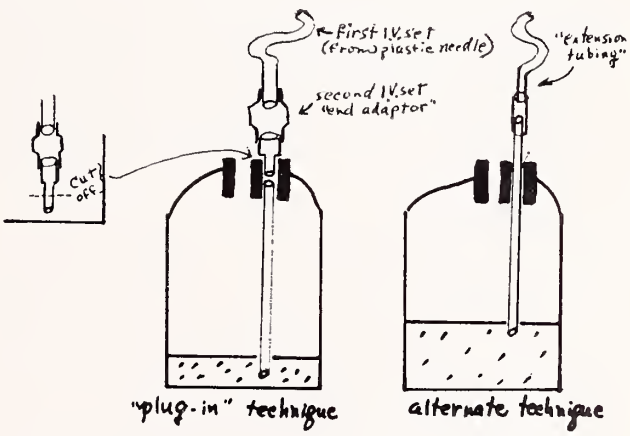


Figure 7. a) Second I.V. set tip is cut off (2-3 mm.) so as not to dislodge the under-water-seal tube of the standard I.V. bottle when tip is inserted into rubber top of bottle. b) Alternate method of advancing the under-water-seal tube and use of standard anesthesia extension tubing as connector.

VA Medical Lecture September 18

"Metabolic Effects of Shock" will be the title of a lecture to be presented at 1:30 p.m., September 18, at the Veterans Administration Hospital in Des Moines. The lecture will be presented by William Schumer, M.D., of Chicago, Illinois. Dr. Schumer is chief, Surgical Service, Westside V.A. Hospital, Chicago, and associate professor of surgery, University of Illinois.

Interested Iowa physicians are invited to attend the September 18 meeting.

Reproductive Factors Associated With Radiotherapy of Malignant Lymphomas

DONNA L. SOOBY, Ph.D.
HERBERT L. JACKSON, Ph.D., and
A. CURTIS HASS, M.D.
Iowa City

THE QUESTION OF GONADAL DOSE is not ordinarily a major consideration in radiotherapy. There is however a group of patients which constitute an exception: namely boys and young men suffering from the various malignant lymphomas. Their outlook is by no means hopeless as long-term remissions and even *cures* are quite possible. After treatment a number of these people want and are capable of siring children. Since many must be treated in areas near the genitalia, the question of gonadal exposure and its possible effect upon their offspring must be considered both by the patient and his physician.

The therapist must ask himself, "How far can I reasonably go in reducing gonadal exposure without seriously risking the patient's life?" The patient must face the question, "In view of my radiation history should I renounce fatherhood?" The purpose of this article is to explore these questions so the therapist and those in a position to advise the patient professionally can answer intelligently.

SPERM KINETICS

In our clinic, after we complete radiation treatment with inverted "Y" fields using gonadal shields on patients with malignant lymphomas, the total testicle dose has been estimated to be 150-200 rad.[3] Since this total dose is received over a period of four weeks in single doses of 5-10 rad and not as a single, acute dose, undesirable reproductive effects are greatly diminished.[7]

The authors are members of the staff of the Department of Radiology at the U. of I. College of Medicine.

For many reasons, some of which have been discussed by Zuckerman,[11] there is little data available on the kinetics of sperm maturation depletion* and regeneration for the human male. Recognizing that the effects of fractionated doses do not follow the same time course as one acute dose of radiation, we can nevertheless make a rough estimate of the time required for complete testicular recovery from irradiation from the data reported by Oakes and Lushbaugh.[4] A 34-year-old male was accidently exposed to radiation doses estimated to be equivalent to 390 R of 80 KV X-rays and 26.4 R of gamma rays to the total body. He experienced a period of complete sterility for six to eight months. Fertility gradually returned with regeneration of the germinative epithelium, but the sperm count remained permanently depressed. The regeneration process had nearly stabilized three and one-half years after exposure. At this time the sperm count had tripled from 5 x 10^6/ml. one month after exposure to 16-17 x 10^6/ml., but was still only about 25 per cent of the generally accepted minimum concentration required for fertility. Despite this gross reduction in fertility, the man succeeded in fathering a normal child six months later. A year later, or five years after the exposure, the sperm count remained below 20 x 10^6/ml.

The above facts imply that the regeneration time for the human male is much longer than for other mammals. Rats, mice and rams all show normal sperm counts 3-5 months after X-ray doses of 400-800 R. Oakes and Lushbaugh[4] suggest the extended regeneration time for man may mean that there are fewer radioresistant, primordial cells present in the germinative layer of the seminiferous tubule than

* The term maturation depletion refers to the maturation of spermatocytes and spermatids after spermatogonial division has ceased. This process necessarily leads to the depletion of sperm in the testicles and decreased sperm concentrations as successive sperm counts are taken.

in other mammals which have been studied. The duration of spermatogenesis is also longer for man, but not enough to contribute significantly to the extended regeneration time. Heller and Clermont[2] estimate that spermatogenesis in the human male requires 64 days, compared to 49 days in the ram and 48 days in the rat.

CHROMOSOMAL ABERRATIONS

One of the major effects of ionizing radiation on cells is the production of abnormal chromosomes. As early as 1908, Regaud and Dubreuil[6] found that embryos conceived immediately after gonadal irradiation of the sire had a much higher embryonic death rate and considerably more abnormalities. However, it has been shown by many investigators[8] that embryos conceived after the period of sterility do not show these effects of irradiation. It is now generally accepted that the deaths and abnormalities, which are characteristic of embryos conceived immediately after irradiation of mature and developing sperm in the testicle, are due to the presence of radiation-induced chromosomal aberrations in the sperm. It is also generally accepted that the many divisions which a spermatogonial cell undergoes as it differentiates into a mature sperm prevent the great majority of cells with abnormal chromosomes from becoming mature sperm. Thus, the radiation-induced chromosomal defects present in sperm during the initial fertile period are absent from sperm produced after the period of minimal fertility subsequent to irradiation.

GENETIC MUTATIONS

A second type of hereditary change which is induced by radiation is gene or point mutations. In principle, these may be either dominant or recessive. Dominant lethal mutations cause prenatal death, semi-lethals (such as hemophilia) cause death before reproductive age, while sub-vitals decrease the life-span of the mutant. Recessive mutations, however, do not produce aberrant individuals except in the homozygous state which is achieved only by inbreeding.[10] With our current marriage laws and highly mobile population, the probability of two radiation-induced recessive genes appearing in any given individual is rather remote, but individuals carrying a detrimentally recessive gene in the heterozygous state are frequently less viable and more susceptible to the various ills and aches to which man is heir. While the overt damage during the first several generations caused by a detrimental recessive mutation is slight or even non-existent, the long range outlook is different. According to geneticists, if one considers all future generations, the total damage wrought by any detrimental gene will ultimately be equivalent to one death.

Several studies have been carried out in which enormous numbers of animals have been examined for the presence of gene mutations produced by irradiation of the testicles of their sires. Cox and his co-workers,[1] by analyzing blood groups and serum proteins, tested 40-50,000 gene loci in the offspring of irradiated boars. As was expected, since the spontaneous mutation rate is considered to be at least 10^{-5}, they found no evidence of a dominant genetic mutation. The radiation-induced mutation rate would have to be several times greater than the spontaneous mutation rate in order to be detectable in 50,000 cases. Earlier studies reported by Snell,[9, 10] which involved genetic studies with X-rayed mice, yielded only one irregular dominant mutation. Due to the poor viability and subnormal fertility of the affected mice, insufficient data were collected to determine whether it was a true mutation or a deletion.

Thus, present evidence indicates that gene mutations present no immediate reproductive threat to the irradiated male. Dominant lethals apparently do not occur, and the recessive mutations by their very nature are not evident.

POPULATION GENETICS

Regarding the long-term risk, we must consider the patient's irradiation as an increase in that of the population as a whole. The fact that closely related persons do not intermarry greatly dilutes the genetic material of any one individual and thus lowers the chance that a detrimental recessive gene will express itself during the first several generations. It is clear that if the gonadal dose delivered to an individual patient is regarded as being delivered to the general population, then the quantity is negligible compared to that from other sources. From natural background alone, each person acquires approximately 2 rem of gonadal irradiation during the first two decades of life. In a world population of three billion people,

that amounts to 5 x 10^9 rem. The 100-200 rad received by the patient is trivial. Some people claim that *any* addition to the radiation burden is deleterious and must be avoided. Such arguments make sense if the background level is significantly above the optimum value for normal, healthy biological evolution—an assumption for which there is no current evidence.

These facts mean several things to the male patient who receives an extended field of radiation. First, *conception must be avoided during the period of fertility immediately following the radiation treatments* because the sperm involved were irradiated in or near their mature state. Hence a genetic disaster is distinctly possible. Second, when fertility returns, his probability of producing a defective child is essentially the same as for the rest of the population.[1] However, he may bequeath damaged genetic material to his descendents that to some degree may make life more difficult for some of them.

SEMEN STORAGE

The patient may ask about the possibility of collecting and storing semen, thereby avoiding the risks due to gonadal irradiation. This idea is not as attractive as it might first appear. To begin with, a minimum of two or three weeks of collection time must be allowed for each child desired. It is very doubtful if the patient's therapy should be delayed so long.

Furthermore, the semen stored contains only mature sperm, which is far more vulnerable to consequential genetic damage than that generated subsequently. Besides the ever-present background radiation, stored semen is subject to all sorts of physical and chemical effects that have not yet been thoroughly investigated. As far as anyone now knows, the number of recessive mutations introduced into the genetic pool by long-stored semen may greatly exceed that due to gonadal irradiation. For those patients who insist on having children but are concerned about radiation damage, we suggest either adoption or the use of semen from an unirradiated donor.

PROGNOSIS AND PARENTHOOD

Ordinarily the physician tries to give the cancer patient all possible reason for hope even when little or none in fact exists. A more realistic attitude is necessary, however, for the young lymphoma patient who is contemplating a family. He must recognize the odds against his long-term survival and hence the likelihood that his children will be orphaned at an early age. In addition to the problems of a broken home and possibly a stepfather, his children may have to cope with serious financial problems as the patient may well have exceedingly high medical expenditures of his own before death. As a rule of thumb we would suggest that the patient wait not less than two years before starting a family. If at that time he is still symptom-free, the chances of a "permanent" remission are reasonably good.

BIRTH DEFECTS AND PSYCHOLOGICAL FACTORS

Since birth defects are rather common, occurring in two to 10 per cent of all births, the chances that the patient and his wife will have a defective child are fairly high. The parents of defective children almost invariably harbor guilt feelings. If the patient should be unlucky enough to father a child with a gross defect, his guilt burden would likely be enormous and severely detrimental both to himself and to his family. Although, as we have seen, the objective probability of gonadal irradiation producing an obviously defective child is extremely small (provided conception is delayed), the couple must consider in advance whether such a tragedy would trigger off a severe guilt reaction in either of them. If so, child-bearing should be absolutely ruled out. It is altogether possible that the emotional upheaval would have a far more serious effect on the child than the genetic defect itself.

SOCIAL ASPECTS

Throughout history man has been encouraged to reproduce himself in unlimited quantities in order to insure his survival. Large families have not only been socially acceptable, but in some cultures have been considered the only justification for marriage. In recent years, due to the social and financial problems associated with large families in an urban society, four children have been considered to be the optimum number. Currently, however, due to the rapidly increasing population, it has become obvious that the old values which have governed man's reproductive attitudes and behavior are no longer conducive to his survival. If man continues to reproduce himself in the future as he has in the past, the sociologists

and ecologists warn us that in less than 30 years the population overrun will be disastrous. Difficult and painful though it may be, man is now forced to choose between either a drastic reappraisal of his attitude toward reproduction or extinction. There is apparently no alternative.

We must begin to consider parenthood as a privilege which should neither be assumed by everyone nor abused by anyone and not as a "God-given right" of every biologically capable person. It is not the purpose of this paper to enter into the highly emotional and controversial debate as to the means by which the birthrate can be reduced, but since rather drastic measures are soon going to be a fact of life for everyone, we believe it is reasonable to discourage parenthood by any person who has as many negative factors involved in such a decision as does the patient with a malignant lymphoma.

However, if the couple eagerly want children, we would strongly suggest that they wait long enough to assure that no sperm irradiated in the mature state are present and to establish the fact that a cure or a long-term remission is reasonably likely. For this purpose we suggest a waiting period of about two years after radiation therapy.

These considerations, along with the social and economical problems, hopefully should deter most males afflicted with this disease. The therapist should discuss with each couple that contemplates pregnancy the various alternatives to parenthood such as adoption and work with children's charities and social groups. In any event the final decision must lie with the couple, but it is the therapist's duty to be sure that both understand the various possibilities, risks and alternatives.

SUMMARY

There is at present no evidence of radiation-induced or congenital defects in offspring produced after an irradiated male regains fertility. However, due to the various medical, psychological, social and economical factors involved, we recommend a waiting period of two years before conception.

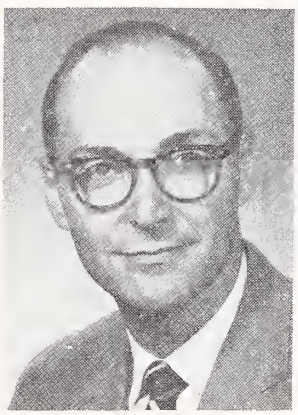
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Named Assistant Deans

Two faculty members at the U. of I. College of Medicine have been named assistant deans for special areas within the College.

Dr. Richard M. Caplan, professor of dermatology and director of the Office of Medical Education, has been named assistant dean for continuing education. In this position Dr. Caplan will continue his direction of the postgraduate education program and will also be responsible for administering the preceptorship program for the undergraduate medical students. A 1955 graduate of the U. of I. College of Medicine, Dr. Caplan has been a member of the faculty for nine years. He is a native of Des Moines.



R. M. Caplan, M.D.



G. L. Baker, M.D.

Dr. George L. Baker, associate professor of pediatrics, has been appointed assistant dean for student affairs. In his new capacity Dr. Baker will coordinate implementation of the new medical curriculum and will direct future development of the curriculum as medical student enrollment increases. Dr. Baker is a medical graduate of the University of Missouri and has been a faculty member at Iowa since 1965. His special areas of medical interest have been premature and newborn infants, nutrition and lipid metabolism.

President's Page



The physicians of Iowa aspire to maintain and improve the health of all individuals. To accomplish this in the long range there is a need for much planning; this planning is in addition to the actual day-to-day delivery of services. Planning must involve many entities.

We must plan our continuing education to include such major problems of the day as drug abuse and alcoholism. Your Society is actively pursuing these problems and arranging programs for your benefit.

Furthermore, the physician is concerned about the citizen's access to medical care and the method of his entry into the system of care. Your IMS officers are prepared to discuss these matters with all members at the informational meetings on Foundations for Medical Care which are planned this month and next. I urge you all to be present at one of these sessions. Please see the *In the Public Interest* page for a complete schedule of these informational meetings.

President

Editorials

EXTRACRANIAL ARTERIAL DISEASE

In a recent article on extracranial carotid occlusive disease from the surgical service of the Ohio State University College of Medicine it is emphasized that if a maximum benefit from endarterectomy is to be achieved it must be done before there is any permanent neurologic deficit.* For this reason it is incumbent upon all physicians seeing patients in the appropriate age group to inquire specifically about symptoms of cerebral ischemia at each "routine" check-up, and to examine carefully the great arteries of the neck for any intimation of an impending cerebrovascular accident. With this approach the physician can select patients for arteriography and determine those who would benefit from carotid endarterectomy.

The article acknowledges the value of carotid endarterectomy in patients with carotid artery stenosis. It is by this approach that the heavy toll taken by cerebrovascular accidents can be reduced and the patient can be spared a life of invalidism.

The study carried out by the Ohio group was done to demonstrate that in a large group of patients having transient attacks of cerebral ischemia and extracranial carotid lesions, rather classic complaints will be present which are quite specific for this condition. A knowledge of these symptoms and signs will assist the physician in his interrogation of the patient and will help him to localize the symptomatic lesion quite accurately. This leads to early diagnosis and an opportunity for remedial treatment before a cerebral infarction occurs.

The Ohio study was a retrospective evaluation of 72 patients who underwent elective carotid endarterectomy at the University Hospital from May 1960 to December 1968. The case records were carefully studied and the symptoms were tabulated. Symptoms which were clearly hemispherical in origin were considered specific for lesions of the carotid system. Among these were transient monocular blindness, contralateral hemiparesis, aphasia, and sensory disturbances of one half the body. Symptoms which were questionably hemispherical in origin were considered suggestive of carotid lesions . . . such as transient monoparesis, unilateral sensory changes of less than one half the body and alterations in speech, usually dysarthria. Some of the patients were asymptomatic or the symptoms could not be ascribed to cerebral ischemia within the distribution of one carotid artery.

In the tabulation of the symptoms of cerebral ischemia among the 72 patients it was revealed that 42 of them (58 per cent) had symptoms clearly arising within the distribution of one carotid artery . . . transient contralateral hemiparesis in 25, transient ipsilateral monocular blindness in 14, and transient sensory disturbances in three. In nine patients (12.5 per cent) there were intermittent symptoms suggestive of, but not considered specific for ischemia in the proven carotid artery lesion . . . transient paresis of one extremity in three, transient contralateral sensory disturbance in two, and transient speech disturbance in two. In 12 patients among the 72, the complaints of cerebral dysfunction were quite nonspecific . . . diffuse headaches, bilateral upper extremity numbness, episodes of lightheadedness, or syn-

* De Voe, S. J. and Marable, S. A.: Specificity of symptoms of extracranial carotid occlusive disease. OHIO STATE MED. J., 66:488-491, 1970.

Editorials continued...

cope, but at operation they were found to have significant extracranial carotid lesions. Nine patients had no symptoms referable to a carotid lesion, but bruits over the carotid artery were detected during examinations for evaluation of peripheral artery disease.

As a result of the study the authors concluded that a large percentage of people having symptomatic extracranial carotid artery occlusive disease will have specific symptoms. Thus, the occurrence of these symptoms in any patient should strongly suggest the possibility of extracranial arterial disease. The careful evaluation and examination of any patients having these transient symptoms, and even in those who are asymptomatic, are extremely important, since they constitute the group which benefit most from surgery. It is generally accepted that surgical intervention after the occurrence of a cerebrovascular accident is of little value.

PARENTS & TEENAGERS

These are trying times for many parents of adolescent children. It too is a very difficult time for a large number of the children who are the cause of parental concern. To this unfortunate and unhappy state of affairs within the home the term "generation gap" has been applied. Parents cannot understand why their teenage children have "turned them off" and why they reject the values and standards and mores which constitute the wholesome way of life of the adult generation. This development has occurred even in good homes where there is love and happiness and good example, and in which a conscientious effort is made to inculcate what is considered important in the shaping of character and personality.

Many adolescents look upon the adult way of life as one of hypocrisy and of false values and standards, and they embrace a new idealism which rejects the false gods of mid-Victorian standards and the virtue of blood, sweat and tears. Youth fails to understand that the dedication of a father to his job and of a mother to the responsibility of the home and family are primarily for their benefit. They fail to recognize this is done to provide an atmosphere conducive to their normal development, to assure them an education and adequate preparation for life, and to spare them the burden of parental care when degenerative disease comes and the shadows lengthen.

Large numbers of youth today subscribe to a new establishment, a hedonistic philosophy, a new morality, the satisfaction of immediate desires rather than deferment for ultimate goals. They resent restrictions. They withdraw from the happy circle of family life and draw a curtain between themselves and their parents and siblings and disrupt the harmony of home. They seek only the approval of their peers. All of this is attributed to protest against the ills of society. They are highly critical of almost every aspect of life, but they offer pitifully few constructive alternatives.

In a recent article* entitled, "The Adolescent in Today's Society" by Dr. George M. Bright, director of adolescent medicine at the University of Virginia, the author recommends certain basic principles to parents in their relationships with teenage children. These principles should be helpful not only to parents but to everyone concerned with the problem. His suggestions are as follows:

1. *Speak with them and not simply to them.*
2. *Give them the facts, . . . no matter how controversial the subject may be, give them the truth.*
3. *Trust them. Even though they may not always deserve it, they will become responsible more quickly, than if every move is watched or if they know they are mistrusted.*
4. *Be consistent. This is important at any age but particularly so at adolescence.*
5. *Maintain firm but friendly discipline.*
6. *Train adolescent girls and boys for independence in every way possible.*
7. *It is helpful for parents to remember their own feelings during adolescence.*

* Bright, G. M.: Adolescent in today's society. VIRGINIA MEDICAL MONTHLY, 97:68-71, 1970.

8. Set limits and enforce them. Standards should be enforced firmly but flexibly.

9. In conflict of issues, the question is not who *is right, but* what *is right.*

10. Exhibit standards of good taste and behavior which you wish them to emulate, but don't demand their compliance to them.

The guidelines suggested by Dr. Bright should be very helpful to concerned parents of teenagers. However, in counseling, physicians must emphasize that the creation of mutual love and respect and trust starts in infancy and should be continued consistently in the day to day relationships within the home. Too often the father has an insignificant role in the raising of children, matters of principle and discipline are left to the mother, when it should be the responsibility of both parents. There is no more rewarding experience in life than raising one's children to become fine, wholesome, useful adults but it must be made perfectly clear that this doesn't just happen. It requires serious thought and effort, a great deal of love, a happy home, consistent principle, good example, and last but not least, a good sense of humor.

THE PROCTOSCOPIC EXAM

In his conclusion Dr. Wycoff reiterates that the idea a "full digitalizing dose" must be given to produce a beneficial effect on the heart is postulated on the belief that the only effect of digitalis is the slowing of the rate of the heart in failure and the correction of certain arrhythmias. The studies in the last two decades have demonstrated that the increase in contractile force is the primary beneficial effect of digitalis. The administration of smaller than those required to slow the heart in atrial fibrillation are effective in improving the function of the heart.

An article* in the May issue of NORTHWEST MEDICINE by a Washington physician tells of the lack of patient acceptance of proctoscopic examination and of his solution of the problem.

The doctor is convinced of the importance of complete physical examinations and preventive measures in the continuing care of the patient. Proctoscopic examination is important for it permits the early detection and cure of potentially lethal lesions. Much to the doctor's surprise and dismay he finds some patients refuse to accept proctoscopy as part of the physical examination. They complain about the large dose of castor oil the night before, the cramping pains and the many trips to the bathroom during the night, and "taking enemas until clear." After such an unpleasant preliminary ordeal the patient is apprehensive about the procedure itself. Hearing so many complaints and having some patients refuse proctoscopy, the doctor began to wonder if it really was an important and necessary part of the examination. The detection of significant lesions in two symptomless patients within a period of a few weeks erased all doubts concerning proctoscopy as an important diagnostic tool.

In an effort to improve patient acceptance the doctor tried many routines of bowel preparation and he finally concluded that the simplest is the best. His current practice is the use of a Fleet enema given in the office and the complete elimination of a laxative the night before and no preparation before coming to the office. This has greatly reduced the anticipatory anxiety of the patient and after a four-year use of this preparation it has been found that the bowel is better prepared than it was with the previous, vigorous routine. Emphasis is given to the fact that in using a disposable enema it is necessary to preheat it in warm water before administering.

Another improvement which helped patient acceptance was the adoption of a very positive attitude on the part of the physician. He explained to his patients that he was about to do a procedure of inestimable value to them, and if discomfort was experienced to have no hesitancy in telling him of it. During the examination the doctor talks to the patient, explains what he is doing, and warns of possible discomfort which may occur.

According to the Washington physician the changes adopted have resulted in the acceptance of office proctoscopy as an integral part of a routine physical examination, and it is no longer a fearful ordeal.

* Bratruda, A. P.: Office proctoscopy. N.W. MED. 69:333, 1970.

INFORMATION FROM THE
IOWA HEART ASSOCIATION

Angiocardiography

MANUEL VIAMONTE, JR., M.D.
FRANK J. HILDNER, M.D.
CARL E. FABIAN, M.D.

Angiocardiography is the radiographic examination of the heart (cardiography) and blood vessels (angiography). Areas of interest are rendered radiopaque by contrast agents which absorb more X-ray than surrounding body tissue. Vascular structures injected with these substances appear relatively white on a darker background.

Angiocardiography employs a variety of equipment and methods and the approach selected must be individualized to the problem at hand. Four factors require special consideration:

1) CONTRAST AGENT

Radiographic contrast agents are organic iodine compounds of low toxicity which can be used safely in total doses of up to 1.5 to 2 ml. per Kilogram body weight during a single examination. Obviously, the injection of smaller individual amounts permits a greater number of injections. This is highly desirable, especially in the examination for multiple sites of pathology. Prior to injecting a large bolus a small test injection should be made. Fall in blood pressure, systemic reaction, or local infiltration may require discontinuation. Mild reactions such as nausea, headache and hypotension are common but transient. Urticaria is infrequent and anaphylactic reaction extremely rare. Most side effects require no treatment other than close observation.

2) MANNER OF DELIVERY

Originally, angiocardiography was performed by the injection of a large volume of contrast material into a peripheral vein. This has been obviated by catheterization techniques in which the tip of a catheter is positioned (under flouroscopic guidance) in the structure to be studied. This technique is termed "selective angiocardiography" and is preferred because it permits the use of much smaller volumes of contrast material and it provides superior anatomic detail by avoiding the opacification of overlapping structures.

Use of a catheter demands relatively high pressures for rapid delivery and the use of an automatic power injector. Smaller arteries (or veins) permit a choice of either powered or manual injection.

3) RADIOGRAPHIC RECORDING

The image intensifier flouroscope, with its attached closed circuit television system, produces an image up to 4,000 times brighter then the conventional flouroscope, yet with lower amounts of radiation. This permits superior visualization and precise positioning of catheters. A videotape recorder attached to the system provides magnetic tape recording of all events for immediate review or for permanent storage. Photographic recording is preferred for the final diagnostic interpretation, however, since the photographic image is inherently sharper than the television image. Either 35 mm. or 16 mm. cine film exposed at 30 or 60 frames/sec. is used for the permanent recording of the angiocardiogram (cine-fluorography).

When rapid filming is not of critical importance and fine anatomic detail is a more significant objective, the study may be recorded on large (14″ x 14″) films serially exposed in rapid sequence (up to 12 per second) by means of an automatic film changer. This system is capable of producing film quality comparable to the conventional roentgenogram. Both methods, cinefluorography and serialography, are complementary and should be available in any angiographic laboratory.

4) CARE OF PATIENT

Angiography is performed with the patient's safety and comfort in mind. Ordinarily, these procedures are accompanied by a minimum of discomfort and a very low morbidity. The angiographer sees the patient before the procedure to explain the study and allay anxiety, and to appraise himself of any clinical information which might influence the method of approach.

Under local anesthesia, the catheter may be introduced either percutaneously or following exposure of a vessel. Thereafter, the patient is generally unaware of the catheter's presence as it passes through the great vessels or into the heart. Injection of contrast agent is accompanied by varible sensations of warmth, depending upon the site and quantity of injection. Monitoring of the patient after catheterization is routine, and rarely requires special attention.

To achieve optimum results with minimum morbidity, angiography should be conducted only by

The authors are associated with Mount Sinai Hospital, Miami Beach, Florida.

experienced physicians (cardiologists or cardiovascular roentgenologists). Adequate monitoring and emergency equipment should be available, including as a minimum, electrocardiographic and pressure monitoring devices, a D.C. defibrillator, oxygen, endotracheal tubes, suction apparatus, and drugs to combat hypotension, sensitivity reactions and rhythm disturbances.

ANGIOGRAPHY

Angiography is performed by injecting a contrast agent in or close to the region of interest. Partial obstruction of a blood vessel appears as a segment of reduced caliber and complete obstruction appears as an abrupt termination. Frequently however, the contrast agent bypasses the area of obstruction through collateral vessels, and opacifies the distal segment of the diseased vessel as the collaterals re-enter. Information thus gained about the length of the obstructed segment and the status of the vascular tree beyond, is of utmost importance in planning possible surgical correction.

Occlusive vascular disease is seen commonly in the carotid, renal, pelvic, femoral, popliteal and coronary arteries. Larger vessels such as the aorta, caval veins and pulmonary arteries may also be involved and are similarly studied. Angiography is also useful in the study of tumors, hemorrhagic states, vascular anomalies, portal hypertension, and certain organ pathologies.

ANGIOCARDIOGRAPHY

The chambers of the heart, not distinguished by routine radiography, may also be opacified so that radiographic estimation of internal size, shape, wall thickness and emptying becomes possible.

MYOCARDIAL DISEASE

Myocardial scarring from previous infarction or diffuse fibrosis is seen as a zone of reduced or absent contractility. Further weakening of the myocardium results in paradoxical motion as seen with ventricular aneurysm. In these cases, the thinned portion of the myocardium bulges outward during ventricular contraction resulting in a saccular dilatation. The opposite condition, that is, abnormally thickened or hypertrophied myocardium is seen as a consequence of increased work-load (i.e. left-to-right shunts, valvular insufficiency) outflow resistance (i.e. systemic hypertension, aortic or pulmonary valvular, post-valvular or sub-valvular stenosis) or from unknown cause (i.e. non-obstructive hypertrophic cardiomyopathy).

CONGENITAL HEART DISEASE

Opacified blood passing through intra or extracardiac shunts or through anomalous vessels reveals the size, location and anatomy of the abnormalities. Stenotic lesions such as coarctation of the aorta and pulmonic valvular stenosis are readily demonstrated by the injection of the opaque medium proximal to the lesion.

VALVULAR DISEASES

When valvular insufficiency is suspected, the contrast medium is injected distal to the valve. Incompetence of the valve is demonstrated by a stream of opacified blood leaking back through the closed valve. The amount of reflux may be graded. Conversely, injection proximal to a stenotic valve allows estimation of the size of the orifice.

CONCLUSION

Angiocardiography has become one of the clinician's most useful diagnostic tools. Rapid advances in catheter technology and development of angiographic knowledge have established this technique as an indispensible diagnostic discipline, and already have earned it a place among the classic advances in medicine. The recent dramatic progress in cardiovascular surgery has depended in great measure on this modality. Further improvements in methods, contrast agents and radiographic equipment may be expected to extend present capabilities even further. Maximum benefit to the patient, however, depends upon the awareness of the clinician as to the proper place of this method in the study of disease, and on the skillful performance of angiocardiography.

Medicare-Medicaid Pay 69%

Figures released by the Social Security Administration show in 1969 the average annual medical bill for persons 65 or over was $692. The bulk of this amount ($529) is underwritten by the federal government, either through Medicare or Medicaid. The average older person's out-of-pocket outlay was $163.

In 1969 Medicare paid $6.3 billion in benefits or almost 47 per cent of the total health bill of persons 65 or older. Medicaid paid 22 per cent or $2.1 billion of the 1969 public costs. Direct out-of-pocket payments for the elderly accounted for $3.2 billion. Medicare paid about 72 per cent of the $2.1 billion spent nationally for physicians' services for the elderly.

STATE DEPARTMENT OF HEALTH

ARNOLD M. REEVE, M.D., M.P.H., COMMISSIONER

Rubella Immunization Program

May 26, 1970, marked the virtual completion of Iowa's Rubella Immunization Program. Ninety-eight of the 99 counties conducted school-based clinics and about 521,000 children received the rubella vaccine for a total cost of approximately $751,734. The one remaining county, Iowa, is scheduled for a clinic in early fall. Make-up clinics will be conducted during the 1970-1971 school term. The scope and methodology of the make-up clinics will be left to the discretion of the individual counties. The Department will provide vaccine and any other assistance requested of it.

The need for a mass rubella campaign became evident some time before the vaccine was licensed in June, 1969. Rough data on rubella syndrome abnormalities and the threat of an epidemic predicted for early 1970 clearly indicated that the Department should be prepared to implement the campaign immediately after vaccine licensure.

Preliminary planning began in February, 1969. On June 19, 1969, vaccine was licensed for general use and planning by the Department's immunization section began in earnest. State and national medical groups granted approval of community wide programs soon after licensure. County medical societies and individual medical practitioners began petitioning the Department to provide assistance in local campaigns. Their leadership and support strengthened our resolve to move as quickly as possible. An unexpected problem, money with which to purchase a sufficient amount of vaccine to conduct an effective and efficient program, became increasingly frustrating to the immunization staff. The federal government would provide about 10 per cent of the needed vaccine. Another 5 per cent could be obtained through funds from the state budget, enough to do some pilot programs but not enough to mount a major campaign. Since traditional sources seemed to be bogged down a new plan was decided upon, to raise the money through private sources.

Initial contact with private industry yielded some moral support but little cash. The state president of the Iowa Jaycees agreed to discuss the problem with his executive committee. But the sum needed, over one half million dollars, seemed out of reach even for an organization as broad and community service minded as the Jaycees. A newspaper article describing the plight yielded an almost immediate response from the United Cerebral Palsy Association. A check for $5,000 and a pledge to contribute an additional $9,500 were presented to the Commissioner of Public Health the same day the article appeared in the paper. During the next several days little else happened. A significant amount of money was needed to get the program off the ground and thereby generate interest and inspire people at the local level to raise funds.

Early in December of 1969 the necessary boost was received. The Governor's office was contacted. Governor Ray met with the immunization staff immediately and quickly agreed that the program must be completed. He asked for a plan of action which was furnished the next day. The Governor approved the plan and said he would find the money to get the program started and offered the services of his office to promote statewide citizen participation and involvement. This was of inestimable value in making the public aware of the program. The Executive Council, on the recommendation and urging of Governor Ray, provided $100,000 from contingency funds. This money, added to what was available in contributions from private organizations, enabled the Department to order the first 100,000 doses of Rubella vaccine for early January delivery. We were confident that a significant portion of the needed funds could be obtained from private sources. However, another unanticipated problem presented itself. Should our campaign to raise funds from private sources be as successful as anticipated, a mechanism for handling what could amount to over one-half million dollars was needed. The Iowa Medical Society was asked for assistance. After expeditious negotiations, the Iowa Medical Society and the Department agreed to a method of managing the funds through the Scanlon Medical Foundation, a non-profit fund. Because of quick action by the Governor, the Iowa Medical Society and the Department, Iowa's program was ahead of other states and received priority consideration in obtaining vaccine.

As planned the first 100,000 doses of vaccine purchased permitted the Department to schedule clinics in about a dozen counties which agreed to pay for each dose administered to their children. This in turn, enabled the Department to order ad-

ditional vaccine for delivery in early February and so the cycle went.

The Jaycees, prompted by State Senator John M. Walsh of Dubuque, agreed to act as liaison for local fund raising in most of Iowa's counties. Eventually thousands of people and hundreds of organizations throughout the states became involved in raising funds, publicizing the clinics and assisting the Department in organizing the program.

Eight members of the Department's Preventive Medical Service Staff started conducting clinics the middle of December. During the next five and one-half months, excluding travel time, they spent 1,009 hours in clinics held during the school day and 191 hours in evening sessions. Clinics were held in 1,305 schools. Students from approximately 170 schools in which clinics could not be held for one reason or another were transported to the nearest clinic. Hundreds of physicians donated over 1,200 hours of their time to participate in the program. Over 10,000 lay and professional volunteers donated time as staff for the clinics.

The Department expended approximately $14,000 for travel and subsistence of the immunization teams, $22,000 for printing and $6,800 for clinic supplies. Expenditures for salaries of state employees directly involved in the Rubella Campaign totaled $52,899.60. Although these salaries would have been paid regardless of whether a program was conducted they must be included to present a more accurate total cost figure. The cost of vaccine administered, and on hand, was $656,779.

The total number of children immunized during the 1,200 hours of clinic sessions was 521,036. Of these 129,572 were children under 5 years of age, and 391,464 were school children. The number of children estimated to be eligible for vaccine (over 1 year old and less than 13 years old who had not previously received rubella vaccine) was approximately 590,000. Therefore the initial thrust reached 88.4 per cent of the target population. Some make-up clinics have been conducted and others will be. Two or three per cent may be added during the next school term. At the present rubella immunization level, Iowa ranks first in the nation, setting a goal other states will have difficulty reaching.

The success of this program can not be attributed to any one person, group of people or organization. The objective was accomplished because of the people of Iowa. This was a program of, for and by the people. The Governor, other government officials, legislators, county supervisors, physicians, nurses, school personnel service, social and charitable organization members and "John Q. Public" saw the problem and a solution. Many of the most active volunteers were people who had never before been involved in a community project of any kind.

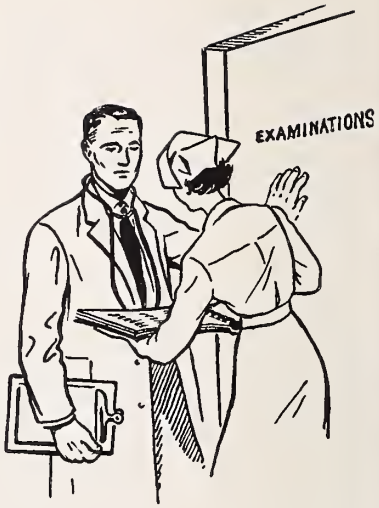
It would be impossible to mention all of the thousands of people who made significant contributions to the success of this program. But one group in particular deserves special mention, the children ages 1 through 12 who courageously (most of the time) stepped smilingly (some of the time) before that frightening instrument and received the vaccine. Most of them felt very little pain when injected, but they didn't know that in advance. Some of them, between 1 per cent and 3 per cent, have endured post vaccination reactions on a scale from mild to severe. It is hoped that the future will show that their discomfort for a relatively short period of time will have prevented lifetimes of suffering for other children and parents.

Morbidity Report for Month of July 1970

Diseases	July 1970	1970 to Date	1969 to Date	Most July Cases Reported From These Counties
Brucellosis	6	28	26	Dubuque
Chickenpox	38	4106	3415	Clinton
Encephalitis				
California	1	1	0	Polk
German measles	19	1999	2207	Dubuque, Polk
Gonorrhea	565	3085	2350	Scattered
Histoplasmosis	3	9	9	Carroll, Marion, Poweshiek
Impetigo	12	282	237	Cherokee, Scott
Infectious hepatitis	19	202	247	Dubuque, Scott
Infectious mononucleosis	16	355	380	Johnson, Scott
Leptospirosis	1	3	0	Page
Malaria, imported				
P. falciparum	1*	4	3	Johnson
P. vivax	6	12	6	Dallas, Linn, Polk, Tama, Wapello
Measles	84	1056	327	Clinton
Mumps	23	2279	3930	Black Hawk
Pneumonia	76	583	310	Scott
Rabies in animals	19	65	61	Henry
Rheumatic fever	3	39	28	Buchanan, Johnson, Wapello
Rocky Mountain Spotted Fever	1	1	7	Linn
Salmonellosis				
S. anatum	1	2	0	Pocahontas
S. javiana	1	1	0	Polk
S. newport	1	2	13	Polk
S. typhimurium	1	14	25	Scott
Group B	1	5	12	Lee
Shigellosis				
S. flexneri	2	3	3	Muscatine, Polk
S. sonnei	5	43	21	Black Hawk, Dubuque, Polk, Webster
Streptococcal infect.	307	4364	2881	Johnson
Syphilis	59	327	417	Scattered
Tetanus	1*	1	0	Scott
Tuberculosis, active	14	85	85	Polk

* Delayed

THE DOCTOR'S BUSINESS



The Medical Assistant Key to an Efficient Office

LARRY E. LEAVERTON
Des Moines

Congratulations to the Iowa Association of Medical Assistants on its forthcoming role as host for the fourteenth annual convention of the American Association of Medical Assistants. The convention will occur in Des Moines in October. The convention theme, "Reap a Harvest of Education" places appropriate emphasis on continuing education.

Capable, well-trained medical assistants are becoming more and more necessary in the well managed office. As the pressure of additional patient visits continues to mount, many physicians are increasing their productivity and providing more service to more patients by delegating more duties to well trained medical assistants.

The subject of delegation of duties to medical assistants is frequently controversial. Some physicians are successful in delegating certain duties without detracting from the quality of care. Others are opposed to losing "the personal touch" and prefer to do almost everything themselves. The importance of greater productivity is evident when one considers that a three per cent increase in the productivity of all physicians would be equal to one year's medical graduating class.

One physician has been quoted as saying that something is lost in delegation, but he admits it is inevitable. He recognizes he cou'd do a much better job seeing three or four patients a day, doing everything by himself, but he knows too he would be doing an extremely poor job of meeting his community's health needs.

The question is often asked, "What more can be delegated?" A logical answer is—anything your medical assistant can do well, under your supervision of course, and which does not detract from the quality of medical care to the patient. All of this must be within ethical and legal limits.

On the subject of delegation these questions are asked:

1. Have you thought about your medical assistant assuming greater responsibility?
2. Is there available any additional training in or out of the office to equip them to assume more duties or responsibilities?
3. Could any changes be made in your established routines to allow for the delegation of more duties?

Once the doctor has made the decision to delegate more tasks, what steps should be taken? You first must decide which additional tasks your assistants should perform and are capable of performing effectively. This will depend on many factors including your temperament, the assistant's level of training, the type of patients you see, and the time available. All physicians should strive to increase the competence of their personnel. They need assistants who can assume more responsibility, who can get along well with patients as well as with the other employees in the office. Existing personnel should be encouraged to improve their skills through on the job training and by taking courses related to their work.

Proper selection is extremely important if an office is to be staffed with capable medical assistants. Before the interviewing and selection process is underway, define the job you are filling and determine the qualifications of the person you are seeking. For example, one type of person is necessary for reception and telephone work, another type is needed for bookkeeping or billing, and still another for assisting with examinations. There is no ideal age bracket for employees in a medical office. Don't overlook the bright young girl with little or no experience who has good potential and the apparent ability to learn and work under supervision. Nor should you pass up a mature and stable older candidate who is in the labor market because of her choice or to supplement the family income.

Some medical offices expect above average performance and offer average or below average salaries. You should be aware of salary levels in your locality. Pay above average salaries and expect top performance. Once set, salaries and work performance should be reviewed periodically.

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REQIPAK® (strip pack), Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)
Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed.



American Association of Medical Assistants

State of Iowa, Inc.

Reap a Harvest of Education

Physicians are showing an increased interest in delegating more responsibility to allied health personnel, and the members of the American Association of Medical Assistants will be better equipped than others to accept such responsibility.

This statement by AAMA President Ruth H. Dize will be reflected in the program of the Fourteenth Annual Convention in Des Moines, October 28-31, 1970.

The opportunities offered at a National meeting are many. The AAMA educational program has always claimed prominence and at least six specialty workshops will be conducted by teams composed of one physician and one medical assistant; each team will explore its particular field. Specialties will include family practice, internal medicine, obstetrics and gynecology, ophthalmology and orthopedics. A seminar on office management will appeal to those who specialize in this work.

Be sure to take part in the Mini-test for Certification. This challenging examination may indicate you already qualify for Certification or that you may need just a little more study to become a Certified Medical Assistant. Only you and the computer will know the results.

In keeping with tradition, the President of American Medical Association, Walter C. Bornemeier, M.D., of Chicago, will be the luncheon speaker on Friday, October 30. Mrs Elizabeth Hendryson of Albuquerque, New Mexico, will be the keynote speaker in the field of organizational effectiveness. She is a former staff member in the Communications Division of the American Medical Association and the wife of Irvin E. Hendryson, M.D., vice-chairman of AMA's Board of Trustees. Her inspirational talk will set the tone for the four organizational workshops on Saturday afternoon, October 31. These will be devoted to Constitution & Bylaws, Education, Membership and Public Relations.

AAMA Conventions always include informal gaiety along with their serious pursuits and at 5:00 p.m. on Wednesday, October 28, a ribbon-cutting ceremony will open the exhibits area. From then until 6:30 p.m. everyone will be guests of the Iowa Association at a welcoming social event in the exhibit area. At 8:00 p.m., the Virginia members will take over for an hour as hostesses for the traditional President's Reception. The "Campaign Cornucopia" will get underway at 9:00 p.m. with Glen Griffin, M.D., Bountiful, Utah, as master of ceremonies. At this time candidates for elective office will be presented and those states bidding for future conventions will campaign.

On Friday evening, October 30, costumed conventioneers will frolic at the "Harvest Hoedown" at the Veterans Memorial Auditorium. Those who learned the hula last year in Honolulu can now master the patters of "Do-si-do" in one, easy lesson. On Wednesday and Thursday reference committees will be meeting and the House of Delegates will be in session. Plan to attend some of these sessions to see your organization in action!

Pre-Convention activities begin on Monday, October 26, with scheduled tours of the Amanas, with an optional side trip to Herbert Hoover's birthplace at West Branch. There will also be tours of the Des Moines Art Center and Salisbury House. The Post-Convention Tour to Mexico is another exciting feature and further information concerning all these events can be obtained from AAMA Executive Office, 200 East Ohio Street, Chicago, Ill. 60611, or from any member of the State of Iowa Medical Assistants.

For those with creative talents, Iowa will inaugurate a "first" this year. An arts and crafts exhibit will feature painting, sculpture, needlework, ceramics, etc.; "blue ribbons" will be presented to the top entries at the Awards Luncheon on Saturday. This particular exhibit will be for AAMA members only and official entry blanks may be obtained from Mrs. Jean Kinsey, Chairman, AAMA Arts & Crafts Fair, 1021 Third Ave., S.E., Cedar Rapids, Iowa 52403.

Many hours of planning have gone into the arrangements for this National Convention. Co-chairmen, Marian Little and Lucille Holmes, working closely with AAMA President Ruth Dize of Norfolk, Virginia, and Executive Secretary Dene Murray from our Chicago office, have put together an outstanding program and *you need not be a member to attend.* In addition to the actual program you have the chance to meet medical assistants from all over the country including Alaska, Hawaii and Puerto Rico. Let's welcome them with real Iowa hospitality!

The annual mid-summer seminar will not be held this year since we are all hard at work for the convention. See you in Des Moines the last week of October—mark your calendar and send in your reservation now!

JEANNE D. GREEN

Woman's Auxiliary News

Leaves From the President's Notebook

" 'The time has come,' the walrus said" and so my time is here to tell you about state activities since May. Iowa had its full complement of delegates and alternates at the national convention and I would like to personally congratulate those Iowa women on national committees about which there is more elsewhere in this issue.

I was happy to hear that the national theme is *Service and Concern for the Reponsible Adult.* We must all accept and discharge our responsibilities for health care. Then freedom was stressed; gratitude for the freedoms that remain to us and a plea for their protection. Good old-fashioned patriotism. We have a great privilege and a duty to work harder than we've ever worked for candidates this fall who will represent our views with integrity. We are fortunate that Trudie Beattie, our state legislative chairman was elected as vice-chairman of the Republican Fourth District. She will do a splendid job. Congratulations to her and best wishes to all of you who are standing up to be counted.

When I returned from convention I settled down to read reports that Jeanne Coughlan gave me in Chicago. Statistical and narrative reports from all of the county presidents. I wrote a personal letter to each one and have received some delightful responses. Even one telephone call. Thanks!

Our Executive Committee Meeting, July 13, was profitable and enjoyable. Recommendations will be read at the next Board Meeting. Bunny Wicks came on her birthday; so after eating Col. Sanders' best we celebrated traditionally. (All Board Members who have birthdays September 21 or 22, please notify me.)

The Year Book is being proofread and should be ready as you read this.

It's time to get in gear for the year's activities. Officers, committee chairmen and members, let's see what we can do to implement each other's efforts—particularly in membership. Councilors need your cooperation on names and addresses; one thing we can *all* do is *recruit.* We may not have many chances left to speak for organized medicine. Let's Preserve, Protect and Promote.

All of my August thoughts are centered on meeting you in Ottumwa September 21 and 22. The Annual Meeting Planning Committee will be in session Monday afternoon. Plans are cooking for an enjoyable dinner meeting that evening for all Board members, Wapello County Medical Society and its Auxiliary members. Tuesday noon my local Auxilians will be hostesses for luncheon. There is a new project to present which will provide a concrete, specific way to implement our theme of Service to Someone, Somewhere and also be the best ammunition for building membership.

The children will be in school, out-of-town football games won't be underway; it's a beautiful time of year to travel—so Board Members COME to OTTUMWA, September 21 and 22. Details will be mailed to you!

—Marion Prewitt

Resolution

The following resolution on health care of the poor was passed during the national convention:

WHEREAS, the House of Delegates of the American Medical Association, at the 1969 convention, adopted a resolution promoting a program on health care of the poor; and

WHEREAS, the resolution recognizes the basic right of every citizen to have available to him adequate health care; and

WHEREAS, the resolution recommends that the medical profession, using all means at its disposal, endeavor to make good medical care available to each person, therefore be it

RESOLVED, that the Woman's Auxiliary to the American Medical Association recommend that the Program Development Committee implement this program on Health Care of the Poor to include Indian, migrant and ghetto care.

Mrs. Tenney at Inaugural

(Mrs. Phillip Tenney received a special invitation to inaugural ceremonies for Dr. Bornemeier. She and her late husband were old friends of the new AMA president.)

It was my privilege to attend Dr. W. C. Bornemeier's inauguration as the 125th president of the American Medical Association in Chicago, Illinois. The preliminaries to the inauguration were very stately and appropriate for the occasion. On a half balcony above the podium were the presidents of each state medical society. As these distinguished men were introduced, each stood and was spotlighted. In a like manner, the AMA officers and Board of Trustees, who were seated in front of the podium, were introduced.

Dr. Bornemeier believes we are continuing to experience a revolution in health care—that during the last 30 years medicine has changed from an art to a science. Financing of health care is increasing in complexity, and there is a great shortage of physicians in the ghettos and in other locations. According to the new president, government and physicians are beginning to work together on these and other health care problems.

The new AMA president contends the number one priority should be to increase the production of physicians. In his opinion this could be accomplished by: (1) reducing the time spent in pre-medical school, the last year of pre-med should be the first year of medical school; (2) by reducing the number of unnecessary courses; and, (3) by eliminating summer vacations. This, then, would reduce to 24 months the time spent in medical school and a new class could start every six months.

Dr. Bornemeier also thinks we should take a close and critical look at our training programs and ask ourselves if they are efficient and effective. There are 40,000 physicians in residency programs, 10,000 to 12,000 are employed to teach in the medical schools and the research field employs many more. Dr. Bornemeier advised that increasing the educational facilities for paramedical personnel and entrusting to nurses more responsibility would be two ways of easing the physician shortage.

In closing, the 125th president congratulated the AMA convention participants on the statesmanlike manner in which the controversial issues were met.

—MRS. PHILLIP TENNEY



RECEIVES RECOGNITION—Mrs. Howard Ellis, of Des Moines, is shown here with a picture presented to her at the Auxiliary's national convention in recognition of her service as chairman of the American Medical Association Education and Research committee of the Woman's Auxiliary to the AMA. Mrs. Ellis, a past president of the Iowa auxiliary, was named to a second term as chairman of the national committee at the annual convention in Chicago.

Did Your Miss Our NEWS in July?

In action taken by the Board of Trustees of the Iowa Medical Society, it was decided to limit the July issue of the JOURNAL to proceedings of the IMS Annual Meeting.

My grateful thanks to all of you who sent material for The News through the summer. I assure you it will appear subsequently.

Since I have had no formal training to qualify me, it was helpful, indeed, to attend the session for state editors at the Auxiliary convention in June. I beg your continued help!

—YOUR EDITOR

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Highlights of the 47th National Convention

To the usual visitor, the city of Chicago means the Loop, Lake Michigan, the Palmer House, the Prudential Building. . . . But, for the nine Iowa women attending the national meeting of the Woman's Auxiliary to the American Medical Association, June 21-25, was more. It meant mingling and exchanging ideas at the Drake Hotel with more than 1,000 physicians' wives from all over the U. S. A.

Iowa was one of 36 states to be fully represented. Listening and participating were the delegates elected in April at the Annual Meeting: Mrs. Daniel Coughlan, Mrs. Max Olsen and Mrs. Joseph Kehoe; and alternates, Mrs. Howard Weis, Mrs. James Bishop and Senator Charlene Conklin. (Elected but unable to attend was Mrs. E. A. Vorisek.) State President Mrs. Leland Prewitt and President-elect Mrs. Phillip Tenney filled two of the five seats allotted to Iowa. Mrs. Howard Ellis was a national delegate.

On Sunday, the Auxiliary sponsored a beautiful reception honoring Mrs. John Chenault, president, of Decatur, Ala., and Mrs. R. C. L. Robertson, president-elect, of Houston, Texas.

The convention formally opened on Monday, June 21, when the 339 delegates took their assigned seats behind the national officers, honorary members and past presidents. Each day the hall was filled with alternates, members and guests.

Mrs. Chenault presided over the sessions with efficiency, poise, patience, and, yes, even good humor. For example, Mrs. Chenault asked the assemblage on Tuesday if they had not wondered about the males scattered about the hall on Monday. There was a titillating hint of merriment in her voice when she explained that they had been there to handle the rumored invasion by a group from Women's Liberation.

Mrs. Louise Bushnell, director of women's activities for the National Association of Manufacturers, offered a "Challenge to Women in the '70's" in the keynote address by calling on them to find answers to the world's greatest problems. "Clean the cerebral cobwebs, first from ourselves and then others," she said. By ridding ourselves of snob appeal in tone, facial expression or words, she conjectured that with understanding we might help to find peace in race relations. She urged all to become deeply involved in the November elections by giving 2-5 hours a week, early enough to help. Saying that the next 10 years may decide the degree of freedom we will have; if we refuse to help, we will have no right to criticize.

Gerald D. Dorman, M.D., 1969-70 AMA president, was the guest speaker at the "Heavenly '70's" luncheon honoring AMA officers, trustees and wives on Monday noon.

Following the luncheon Mrs. Chenault presented a check for $498,950.69 to Robert C. Long, M.D., president of the American Medical Association Education and Research Foundation. Mrs. Howard Ellis received an award for outstanding work for this contribution which represented an increase of $70,000 over last year. Mrs. Chenault noted that physicians' wives had given a total of of $4,196,083 to the Foundation since the Auxiliary adopted the project in 1951.

Mrs. G. Prentiss Lee presided over the Idea Exchange that began on Monday afternoon and continued through Tuesday morning. It was at these sessions that Iowa's past-president, Mrs. Daniel Coughlan, spoke eloquently of instructive and informative board meetings as vital to the esprit de corps of Auxiliary; zeal thus created in leaders providing the necessary enthusiasm at the grass roots.

She continued: Many members of the general public think that doctors' wives are endowed with medical training and ability. This may be true occasionally, but the majority apparently are supposed to have gained this ability by propinquity or osmosis. Fully aware of deficiencies, the study of first aid became the extra-curricular subject at board meetings. The safety and disaster chairman had a special competency in the field and was thus able to act as instructor. The material covered included: artificial respiration; external cardiac massage, recognition and treatment of shock, treatment of burns, heat prostration and stroke, accident prevention, preferred methods of rescue and appreciation of various types of intoxication that mimic illness. Each board member was encouraged to disseminate the information gained to her local group. What would you do if you were confronted with a serious medical emergency? Don't you think you should be prepared to act?

The "Show and Tell" presentation of exhibits developed by state and county auxiliaries was well attended by delegates. The entire convention provided an unparalleled opportunity to hear about the outstanding accomplishments of auxilians and auxiliaries and to learn about new plans.

In the concluding remarks of her inaugural address, Mrs. R. C. L. Robertson, the 1970-71 national president, urged Auxiliary members to accept responsibility for the promotion of better health in the community and to be aware of neighbors' needs.

NATIONAL OFFICES TO IOWANS

• Mrs. Howard Ellis will serve a second year as chairman of the Program Extension Committee-AMA-ERF.

• Mrs. Max Olsen was elected and installed to serve as director on the National Board for two years. Mrs. Olsen has been regional chairman of the Health Careers Committee for the past two years.

• Mrs. James Bishop was reappointed North Central Regional chairman on the Mental Health Committee.

Volunteer Health Service Winner—1970

Ruth Bousman is a friend who lights up the lives of others!

Years ago when she and her family were plagued by a series of misfortunes she vowed to devote time and energy to helping others if the Lord saw them through. Ruth kept that promise and the Iowa Medical Auxiliary honored her with the Volunteer Health Service Award at its annual meeting in April. The Community Services chairman, Mrs. D. E. Howard, of Sioux City, made the presentation and two friends of the recipient accepted in her absence and spoke devotedly of her work.

Mrs. Gary Bousman was born in 1917 in Grand Rapids, Michigan, and after high school attended business college there. She worked as a secretary until her marriage to the Reverend Mr. Bousman in 1941. They have three sons: Gordon, married and majoring in business administration at The University of Iowa; Ronald, also married and a medical student at Iowa, and Bruce, in the army. They have served United Church of Christ congregations in Wisconsin, New York, Minnesota and North Dakota, with Ruth assisting in work of each congregation. At Fargo she was reserve librarian at the University for two years and in 1961 her husband became chaplain at the V.A. Hospital in Knoxville, Iowa.

In March 1970 she resigned as secretary to the Superintendent of Knoxville schools, a position Ruth held for eight years. She is a member of the National Association of Educational Secretaries and is a free lance writer with poems and articles published in PROFITABLE HOBBIES, where she appeared on the cover, CHILDCRAFT and others. An article in LADY'S CIRCLE magazine was about the work Befrienders are doing at the Marion County Home in Knoxville. It was written in the hope others would become aware of the desperate need for companionship, friendship and activities among people in county homes and other similar institutions.

Ruth's interest in county homes began in Fargo and six years ago she went to the home in Marion County. She found women so destitute of hope they stayed in bed all day, they lacked recreation and had no one who cared. Many would not utter a word and gave no sign they were aware of their surroundings. Most of the residents had been transferred from mental institutions and their ages ranged from 18 upward.

Mrs. Bousman began talking to her friends about the needs. She recruited and organized a group of 20 volunteers called The Befrienders. They "chipped-in" for craft supplies, calling their contributions dues. Now service clubs and church groups help out financially. At various levels everyone at the Home can do crafts; with careful planning and a consideration of the women's abilities, it has been possible to make useful and lovely things and the look of boredom and hopelessness has declined. They have begun to talk more—even to offer helpful suggestions.

The friendship program blossomed. Now there are parties, programs, carnivals, auctions, a monthly newspaper, ice cream socials and a rhythm band. Now many groups in the community are offering their hands and hearts in friendship. The eyes of the inhabitants of the home are no longer dull and lifeless, now they greet visitors with warmth and affection.

Ruth's efforts are not limited to the local community; she has written to both local and state officials who have supervision over county homes to request better conditions. She has appeared before professional groups to stimulate interest. There is no way to measure what Ruth has done to help people. How far her ideas and efforts have spread is hard to estimate, but it has been nationwide.

Mrs. Bousman surely WALKS AMONG ANGELS, for she asks no reward for her work but the love she receives from those she helps.

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501

President-Elect—Mrs. P. H. Tenney, 203 Second Avenue, SW, Independence 50644

Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312

Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228

Editor of THE NEWS—Mrs. J. L. Kehoe, 111 McClellan Blvd., Davenport 52803

Council Evaluates Foundation Concept

The Iowa Medical Society Executive Council devoted a major portion of its summer meeting to evaluating the philosophy and functions of the emerging medical foundation.

At the July 22 meeting of the Council, K. E. Lister, M.D., Ottumwa, chairman of the IMS Board of Trustees, advised of the Society's representation at a national conference on foundations for medical care. He also reported on contacts made relative to foundation development with the Health Insurance Council of America, the Hennepin County (Minnesota) Medical Society and the Minnesota State Medical Association.

This overall investigative activity carries forth an assignment from the 1970 IMS House of Delegates which requested the Board of Trustees to proceed with an in-depth feasibility study of a foundation for medical care in Iowa. The House requested that specific recommendations regarding the creation of a foundation be submitted to it at the earliest possible time.

Two Californians—both veterans of foundation development and administration—were present at the July Council meeting to share their expertise. Donald Harrington, M.D., and Boyd Thompson, are president emeritus and executive secretary, respectively, of the San Joaquin Foundation for Medical Care. Excerpts from their Council presentations appear below.

In accordance with instructions from the House of Delegates, the Executive Council authorized a fall educational program for Iowa physicians. Thirteen regional meetings are now scheduled in September, October and November to inform Iowa doctors regarding medical care foundations.

In other action the Executive Council endorsed the appointment of a special Society Committee on Drug Abuse; expressed no objection to a Blue Shield recommendation that osteopathic physicians and osteopathic physicians and surgeons be permitted to participate fully in Blue Shield; approved a recommendation that existing Medicare prevailing fee areas be retained until there has been some experience with 1969 charge data; supported a proposed Rapid Disease Reporting System now being considered by the State Department of Health, and endorsed a Department of Health proposal to modify the premarital exam to make routine the testing for rubella.

Experts Tell the Council . . .

Donald Harrington, M.D., president emeritus, San Joaquin Foundation for Medical Care

"The foundation concept is spreading, there are 8,000 doctors in the country signed up with foundations for medical care. The foundation will work with any third party, they must take the minimum standards we develop and must underwrite a program from these.



"We have found that fees are not the problem, but that utilization is; this can be controlled by peer review. We have developed a peer review program where we look at all of the claims that come through . . . to decide if they are proper or not."

With the foundation, "the time, opportunity and tools are available to move in the direction of developing something that will maintain the freedom of the practice of medicine, . . . and the ability to practice medicine in the way we have with the knowledge that our peers are studying us."

Boyd Thompson, executive secretary, San Joaquin Foundation for Medical Care

There is an "awareness on the part of the leadership of medicine that things are not standing still, that a lot of people have a lot of ideas on how you can practice medicine better, a lot of ideas on how medicine could be better organized. We personally believe that there is still an opportunity to insert organized medicine in between the government and the rendering of medical service. Government has learned it doesn't actually want to get into the rendering of medical service, it is too complicated and they would have to take responsibility for rising costs.



"It is really encouraging to see organized medicine meeting the challenge through its existing structure. Foundations are strictly an arm of organized medicine, primarily they have been on a county level, now we are seeing them emerge on a state level. And we are all striving to keep each other informed on foundation developments."



Personals



Dr. George A. Paschal, who has practiced medicine in Hamilton County since 1932, the last 24½ years in Webster City, recently joined the medical staff at Veterans Hospital in Des Moines. Dr. and Mrs. Paschal have purchased a new home at 4515 Sixty-seventh street in Urbandale.

Dr. Robert Hathaway, of Waterloo, was the guest speaker at a recent meeting of the Association of Medical Assistants in that city.

Dr. M. G. Ericsson, a general practitioner in Cedar Falls since 1941, moved to California in August and will become student health director at Azusa Pacific College.

Dr. John C. MacQueen, associate dean of the U. of I. College of Medicine, gave the keynote address at the recent 20th annual convention of the Licensed Practical Nurses Association of Iowa, Inc., in Waterloo. **Dr. Norman J. Siderius,** of Waterloo, also participated in the program.

Dr. Eduardo Reveiz has moved his practice from Leon to Webster City. Dr. Reveiz has located in the offices formerly occupied by **Drs. Faye and W. B. Lewis.**

Dr. JoEllen Hoth, of Burlington, gave the commencement address for 21 senior nursing students at Burlington's Memorial Hospital.

Dr. Ralph Smiley, of Mason City, was the featured speaker at a meeting of the Natural Foods Association held in Ionia. Dr. Smiley discussed the medical aspects of pollution of the air, soil and water.

Dr. William D. de Gravelles, of Des Moines, has been reappointed to the Governor's Committee on Employment of the Handicapped.

Dr. Leslie Bernstein, an associate professor in the Department of Otolaryngology and Maxillofacial Surgery at the U. of I. College of Medicine, spoke on "Velopharyngeal Incompetence," at the annual scientific meeting of the American Medical Association.

Several Webster City area physicians recently participated in an Iowa Regional Medical Program on "The Practical Aspects of Diagnosing and Treating the Coronary Patient." **Dr. Donald L. Warkentin,** associate professor of internal medicine at the U. of I. College of Medicine, provided instruction in electrocardiography and drug therapy. **Dr. Eugene F. Brown,** of Webster City, hosted the meeting.

Dr. F. J. Swift, Jr., who is terminating his Maquoketa medical practice, was honored recently at a reception held at the Jackson County Public Hospital. Dr. and Mrs. Swift are moving to Gainesville, Florida, where Dr. Swift will be associated with the Veterans Hospital and also with the University of Florida Hospital.

Dr. Robert C. Hardin, vice-provost and dean for health affairs at the U. of I. College of Medicine, has received the Banting Medal, the top award of the American Diabetes Association. The award "for distinguished service in the interest of doctor and patient" was presented to Dr. Hardin at a recent meeting of the ADA in St. Louis. Dr. Hardin has served as president of the 2,500 member professional group the past year. The award is named for the late Dr. Frederick G. Banting, University of Toronto physician, who discovered insulin in 1921. Dr. Hardin was also selected at the meeting to be the official professional delegate of the ADA to the Seventh International Congress of Diabetes, which was held in Buenos Aires, Argentina in August.


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Dr. William H. Myerly, chief of surgery at Iowa Methodist Hospital in Des Moines for the past three years, has relocated his surgical practice in Spirit Lake. Dr. Myerly will work at the Dickinson County Memorial and Spencer Municipal Hospitals and will do general, vascular and urological surgery.

Dr. Herbert Stroy, longtime physician and surgeon in Osceola, recently received the American Medical Association's Physicians Recognition Award in Continuing Medical Education.

Dr. Willis M. Fowler, professor emeritus in the U. of I. Department of Internal Medicine, has been honored by the American College of Physicians. Dr. Fowler was recently elected a master, highest membership category in the 16,000-member international medical specialty society. The mastership is bestowed on fellows of the College who have attained eminence in science, research or the practice of teaching of medicine.

Dr. Anthony Leschin is a new pathologist serving the Marshalltown Area Community Hospitals. Dr. Leschin received his M.D. degree from Georgetown Medical School in 1954 and interned at Detroit Receiving Hospital in Detroit. He took his residency in pathology at St. Mary's Hospital in San Francisco.

Dr. H. E. Gude, of Iowa Falls, lectured at an emergency care training session held recently in that city. He utilized an American Heart Association film in his presentation.

Dr. A. W. Shafer, of Davenport, has been elected chairman of the Iowa Air Pollution Control Commission.

Dr. Thomas E. Jessen has joined **Drs. Philip A. McLaughlin** and **Charles A. Skaugstad** in the practice of medicine at Coralville. Dr. Jessen received his M.D. degree from the U. of I. College of Medicine in 1968, and served his internship at Butterworth Hospital in Grand Rapids, Michigan.

Dr. Gerald Miller, a surgeon, has joined the practice of **Drs. Norman Johnson** and **Fred Sperry** in Clarinda.

Dr. Jon F. Wubbena has joined his father, **Dr. Arthur C. Wubbena,** in the practice of medicine at Rock Rapids. Dr. Wubbena is a graduate of the University of Nebraska School of Medicine and served his internship at McKenna Hospital in Sioux Falls.

Dr. Darrell E. Fisher, of Mason City, was a guest speaker at the July meeting of the Wright County Medical Society. Dr. Fisher spoke on the relationship of steroid to bone necrosis.

Dr. Louren Willekes began the general practice of medicine in Sioux Center in July. He is occupying a building formerly known as the Oelrich Clinic. Dr. Willekes received his M.D. degree from Temple University in 1969, and recently completed his internship at Sioux Valley Hospital in Sioux Falls, South Dakota.

Dr. Dennis Upah will enter general practice with **Dr C. E. Douglas,** in Belle Plaine on October 1. Dr. Upah is now serving a year of residency at St. Joseph's Hospital in Denver, Colorado, where he interned after receiving his M.D. degree from Marquette University.



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Dr. James W. Cole, III, has been appointed assistant Medical Director of The Bankers Life. Dr. Cole was graduated from the University of Virginia School of Medicine in 1964 and served as a navy medical officer from 1964 to 1968. Upon leaving the navy, he became an instructor at the University of Virginia and served in that position until now.

Dr. John Vanderheiden has joined the staff of the Fort Dodge Clinic and will be a surgical associate of **Dr. L. J. O'Brien.** Dr. Vanderheiden did his undergraduate work at Iowa State University and spent three years in the army serving as a lab technician. He attended the Creighton University College of Medicine and served an internship at St. Joseph's Hospital in Omaha. He had surgical residences at Maricopa County Hospital in Phoenix, Arizona and St. Francis Hospital in Wichita, Kansas. He also served two years in general surgery at Douglas County and Veterans' Administration Hospitals in Omaha.

Dr. V. B. Mulay has arrived in Dyersville and will begin his practice in the near future. Dr. Mulay, a native of India, received his medical degree from the University of Bombay before coming to the United States in 1964. He has had surgical training at the Veterans Hospital connected with Johns Hopkins Hospital in Baltimore, Maryland, and also at the Veterans Hospital in Phoenix, Arizona.

Dr. Robert Wilcox, of Iowa City, has been appointed director of Student Health Service at the University of Iowa. Dr. Wilcox has been a member of the student health medical staff since 1950 as a physician-psychiatrist and has been acting director of the service since last December.

Two Bloomfield physicians, **Dr. Phil Caster** and **Dr. John Finneran,** have reported for induction into the armed forces. Dr. Caster reported to Ft. Belvoir, Virginia, where he will be a captain in

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the medical corps. Dr. Finneran, who was to join the Gilfillan Clinic staff this summer, reported to Bunker Air Force Base, Indiana. Dr. Finneran is a thoracic surgeon and will be a major in the medical corps. After the two physicians complete their two-year military obligation, they will return to practice at the Gilfillan Clinic.

Dr. Dean M. Harms has joined **Dr. John Sear** in the practice of medicine in Alden. Dr. Harms, a graduate of Alden High School, received the bachelor of science degree from Iowa State University and was graduated from the U. of I. College of Medicine in 1969. He took his internship at the Sacramento, California, Medical Center.

Dr. Robert E. Durnin, assistant professor of pediatrics at the U. of I. College of Medicine, recently conducted an auscultation conference at Clinton's Mercy Hospital. **Dr. George York,** president of the Clinton County Medical Society, was in charge of conference arrangements.

Dr. Robert L. Todd, of Burlington, participated in an Iowa Regional Medical Program held in Des Moines recently. Dr. Todd spoke on the consolidation of cardiac care units—such as has occurred in Burlington with the merger of the Mercy and Eastman units.

Dr. William A. Seidler, Jr., of Jamaica, president of the Iowa Chapter of the American Academy of General Practice, moderated the spring GP refresher course held at Lake Okoboji.

Dr. William C. Shinkle, a diplomate of the American Board of Urology, has returned to the practice of urology at 2705 Grand Avenue, Des Moines. He is in partnership with **Dr. John L. Fatland.**

Dr. James Gannon, of Laurens, has been appointed to a two-year term on the State Board of Examiners for Nursing Home Administrators. This board was created by the 1970 Iowa General Assembly.

Dr. Lawrence T. Donovan, a pathologist, has joined the medical staff at Holy Family Hospital in Estherville. A native of Pennsylvania, Dr. Donovan took his undergraduate work at the University of North Carolina at Chapel Hill, and received his medical degree from Duke University. He received his training in pathology at St. Joseph's Infirmary at Atlanta, Georgia.

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A member of the pediatrics faculty at the U. of I. College of Medicine from 1959 to 1967 has been appointed dean of a new Basic Sciences Program for Medical Education at the University of Minnesota's Duluth campus. **Dr. Robert E. Carter** moves to this post from the University of Mississippi where he has been dean of the School of Medicine and director of the University Medical Center.

Drs. S. A. O'Brien and **T. A. Burke** were honored recently as founding members of the medical staff of the St. Joseph Mercy Hospital in Mason City. The tribute paid to Drs. O'Brien and Burke was in connection with the observance of the fiftieth anniversary of the hospital's medical staff. Special scrolls were presented to the two veteran Iowa physicians by **Dr. James Hendricks,** who now serves as staff president. Dr. O'Brien was the first president and Dr. Burke the first secretary of the St. Joseph Mercy staff.

Dr. and Mrs. D. L. Borgen, of Gowrie, were recently recognized for their 38 years of devoted service to Gowrie and surrounding area at Gowrie's Centennial Pageant. Mrs. Borgen was presented a dozen red roses and Dr. Borgen was given a plaque from the Centennial Committee which read, "In Appreciation to Dr. D. L. Borgen for Dedicated Service to the Gowrie Community —July 2, 1970." A 1929 graduate of the U. of I. College of Medicine, Dr. Borgen interned at Anker Hospital in St. Paul and served as resident physician at Women's and Children's Hospital in Toledo, Ohio, before taking over the practice of Dr. C. M. Erickson in Gowrie after the latter's death in 1932.

Dr. Clifford L. Rask, of Maquoketa, has been appointed city health officer to fill the unexpired term of **Dr. F. J. Swift, Jr.**, who has moved to Florida.

While **Dr. G. M. Dalbey**, of Traer, is on a month's vacation, his son, **Dr. Donald Dalbey** will cover his practice. The young Dr. Dalbey received his M.D. degree at the U. of I. and has just completed two years of internship, the second year being in surgery in Syracuse, New York. He will report to Philadelphia September 1 to begin two years active duty with the navy. Following his navy service, Dr. Dalbey plans to study orthopedics.

Dr. Otto N. Glesne, of Fort Dodge, has been named to the Webster County Board of Health to fill the vacancy of **Dr. Charles Baker,** who is moving to Arizona. Dr. Baker has been a board member since 1966. **Dr. James Habermann,** president of the Webster County Medical Society, recommended the appointment of Dr. Glesne.

Dr. Richard L. Bondi, a 1963 graduate of the U. of I. College of Medicine, has joined **Dr. John G. Napier** in the practice of obstetrics and gynecology in Cedar Falls. Dr. Bondi completed his residency training in obstetrics and gynecology at the U. of I. in 1968 and for the past two years has been in the air force, stationed at Altus Air Force Base in Oklahoma.

The following U. of I. faculty members have lectured abroad this summer. **Dr. Frederick C. Blodi,** professor and head of the Ophthalmology Department, spoke on "Electromyographic Changes in Muscular Dystrophies," at the Oxford Congress at Oxford University in England. **Dr. Hermann M. Burian,** professor of ophthalmology, accepted an invitiation from the German Ophthalmological Society to deliver the centenary address in memory of Albrecht von Graefe, one of the founders of modern ophthalmology. He presented a paper on "Diagnosis and Therapy of Strabismus" at the meeting in West Berlin. A member of the International Society of Urology, **Dr. Rubin H. Flocks**, professor and head of urology, attended the Society's meeting in Japan and took part in a panel discussion which compared urologic education in medical schools, graduate programs, and continuing education programs in England, France, Germany, Japan and the United States. **Dr. Harold P. Schedl**, professor, and **Dr. James Christensen,** associate professor, both of the Department of Internal Medicine, attended the fourth World Congress of Gastroenterology in Copenhagen, Denmark. **Dr. John C. Hoak,** professor of internal medicine, attended meetings of the International Society on Thrombosis and Haemostasis in Montreux, Switzerland, and also presented a paper at the International Congress of Hematology in Munich, Germany. The paper, "Hemangioma With Thrombopenia and Microangiopathic Anemia: An Animal Model," was co-authored by **Dr. Emory D. Warner,** professor and head of pathology and **Glenna L. Fry,** research assistant in internal medicine.

Deaths

Dr. Sigmund F. Singer, 77, retired Ottumwa radiologist, died June 22. Dr. Singer was born and educated in Austria and moved to the United States in 1938, settling in Ottumwa in 1942. He received his medical degree in 1917 from the University of Vienna. Dr. Singer was a past president

of the Iowa Division of the American Cancer Society, past board member of the American Cancer Society, past president of the Wapello County Medical Society and past president of the Radiological Society of Iowa.

Dr. Louis E. Bees, 74, who practiced in Bennett for 45 years, died June 27 at Mercy Hospital in Davenport, where he had been a patient for six weeks. A graduate of the U. of I. College of Medicine, Dr. Bees was a member of the Cedar County Medical Society and the Iowa Medical Society.

Dr. Paul O. Heitzman, 57, of Cedar Rapids, died July 15, after a long illness. A graduate of the U. of I. College of Medicine, Dr. Heitzman practiced in Burlington prior to World War II. After the war he moved to Cedar Rapids where he had practiced for 24 years. He was a member of the Fourth Degree of the Knights of Columbus, Linn County Medical Society, Iowa Medical Society and the American Medical Association.

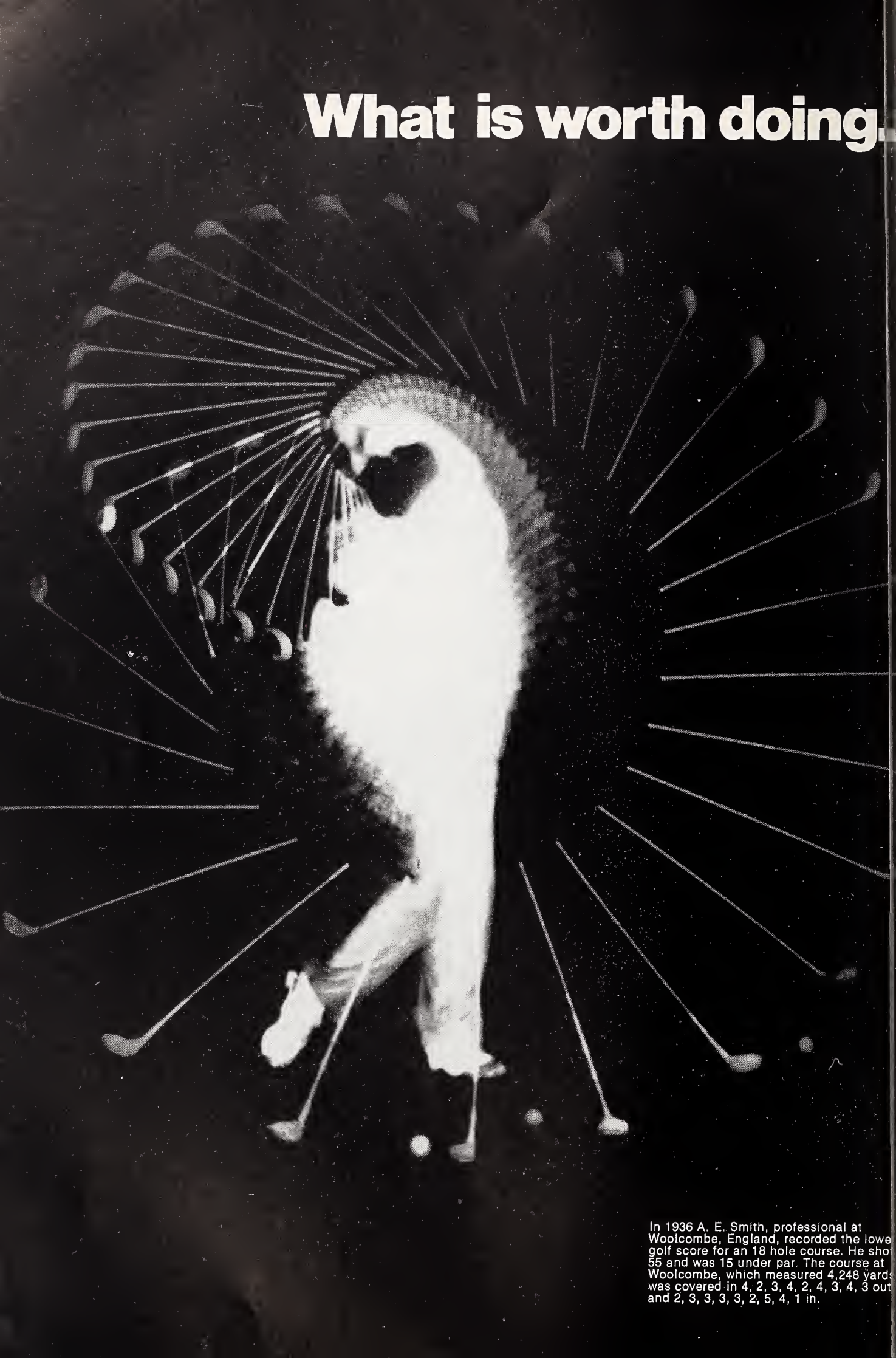
Dr. Isaac Sternhill, 67, a general practitioner in Council Bluffs for over 40 years, died July 11. A 1927 graduate of the Creighton University School of Medicine, Dr. Sternhill was a past president of the Pottawattamie County Medical Society and president of the Southwest Boy Scout Council from 1949 to 1955. He was a member of the Regional Executive Committee for the Boy Scouts and had received the Silver Beaver Award. Dr. Sternhill was president of the staff at Mercy Hospital, on the courtesy staff of Jennie Edmundson Memorial Hospital in Council Bluffs, and an adjunct at St. Joseph's Hospital in Omaha. He was a former member of the B'Nai B'Rith executive committee for the Plains States Region and received its Americanism Award in 1956. Dr. Sternhill served for many years as a member and as chairman of the Iowa Medical Society's Committee on Public Assistance. He served in the Army in World War II as commanding officer of a medical battalion in the North Pacific Theatre and was a member of the American Legion, Veterans of Foreign Wars and the Elks.

Dr. C. H. Mitchell, 87, a Cincinnati physician, died July 1 at St. Joseph's Hospital in Centerville. After graduating from Northwestern Medical School, Dr. Mitchell started practice in New Virginia. He moved to Leon in 1914. His practice in Leon was interrupted by entry into the medical service in France in World War I. At the close of the war, he remained in France for study in the French medical school at Montpelier. In 1928, he came to Indianola and practiced until 1952, when he moved to his farm near Cincinnati and carried on a limited practice for several years before complete retirement. He was a charter member and past president of the Indianola Lions Club.

Dr. Alfred H. Lekwa, 76, of Story City, died July 11 at Mary Greeley Hospital in Ames. Dr. Lekwa graduated from the U. of I. College of Medicine in 1922 and interned at Iowa Methodist Hospital in Des Moines. He practiced medicine in Dows for eight years and moved to Story City in 1931 where he practiced medicine until his death. He served in World War I and was a commander in the navy in World War II. In 1938, Dr. Lekwa assisted in organizing the Boy Scouts in Story City and served as a scoutmaster for a number of years. In 1968, he was presented the "Outstanding Citizen's Award" of the Story City Lions Club. In 1969, he received a 50-year award from the Masonic Lodge and an American Legion 50-year award. He was a member of the Story County Medical Society, Iowa Medical Society and the American Medical Association.

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FOUNDATIONS FOR MEDICAL CARE
INFORMATIONAL MEETINGS

* * *

September	October	November
Tuesday, September 8	Ottumwa (Ottumwa Country Club)	
Thursday, September 10	Dubuque (Dodge House)	
Tuesday, September 15	Creston (Berning Cafe)	
Thursday, September 17	Sioux City (Sioux City Country Club)	
Tuesday, September 22	Cedar Rapids (Roosevelt Hotel)	
Wednesday September 23	Spencer (Stubb's Ranch Kitchen)	
Tuesday, September 29	Waterloo (Elks Club)	
Thursday, October 1	Council Bluffs (Lakeshore Country Club)	
Tuesday, October 6	Davenport (Outing Club)	
Thursday, October 8	Burlington (Holiday Inn)	
Tuesday, October 13	Mason City (Sheraton Motor Inn)	
Thursday, October 15	Boone (Imperial Inn)	
Wednesday, November 18	Des Moines (Hyatt House)	

Society members are urged to attend the meetings in their area

Index to Advertisers

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National Safety Council 658

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Prouty Company 660

Robins, A. H., & Company 642A, B, 654A
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IN THE PUBLIC INTEREST



SCARCELY A DAY goes by in most Iowa homes without a reference of some kind to the subject of health. The interest in health care today is at an unprecedented high in Iowa and across the nation.

There are many reasons why this is true: *The strong desire for quality and quantity in health care. The obvious concern over the short supply of health professionals and paramedical personnel. The feeling that health care delivery patterns of 10, 20 or more years ago do not necessarily constitute a blueprint for tomorrow.*

You may not know that Iowa's health care team, which includes at least 50,000 individuals, needs $500 million each year to sustain itself. This fact alone suggests the magnitude of the health care industry in the state. Too, it says to all concerned and involved persons, we have an obligation and a responsibility to find the best means possible to use these resources to bring good health care to our fellow citizens.

The evaluation of health care delivery and health care economics is a responsibility which has been accepted by the state's medical doctors through their Iowa Medical Society. In its consideration of innovations in the health care delivery system, the medical profession in Iowa has sought to identify and implement those ideas and programs most likely to assure an adequate flow of quality services at a cost fair to both patient and physician.

Right now, in line with the preceding thoughts, the Iowa Medical Society is seriously considering a new dimension in the delivery of health care in Iowa. This concept is relatively unknown in the midwest, and in most of the country for that matter. It has flourished in California where it bears the designation *Foundation for Medical Care.* It is our intention to devote the balance of this discussion to the emerging medical care foundation for the benefit of both physicians and interested non-physicians.

The Foundation concept is now receiving careful evaluation not only in Iowa but in various parts of the country. Its potential is being recognized rapidly. In recent months the state medical societies in Colorado and New Mexico have moved to create *Foundations for Medical Care.*

What is a *Foundation for Medical Care?* What does it do? These basic questions require a thoughtful and deliberate response. The foundation philosophy can be simply stated: It believes that in the hands of the medical profession should be placed the responsibility for making sure that each dollar spent for health care services is a justifiable expense. It further believes the profession should be recognized as that single entity which has the expertise to accomplish this task and should be given the assignment. And finally, it believes the profession should be held accountable for the result.

Those *Foundations for Medical Care* now in existence (they now involve approximately 8,000 physicians, 6,000 of them in California) are incorporated bodies sponsored by state and/or county medical societies. The stated reasons for their existence are enlightening: "To promote, develop and encourage the distribution of medical services by members to the people of an area served and adjacent areas at a cost reasonable to both patient and physician; to preserve unto their members, the medical profession at large, and (the) public, freedom of choice of both physician and patient; to guard and preserve the physician-patient relationship and its innumerable benefits; to protect the public health; to work and study in cooperation with the insurance industry and service plans

UNDER STUDY A FOUNDATION FOR MEDICAL CARE

that provide for periodic and realistic budgeting for medical care, and which subscribe to provide for the freedom of selection of physician and the guarantee of the physician-patient relationship."

Now functioning primarily in the larger counties of California, several of which are similar demographically to Iowa, the *Foundations for Medical Care* have stressed the idea of comprehensive health care and broad coverage of this care. In other words, the Foundations have encouraged programs which prepay medical care the way medicine is actually practiced, in contrast to a mere endorsement of minimal in-hospital medical and surgical programs.

That element within the Foundation concept which appeals most to the Iowa Medical Society is peer review. The medical profession in Iowa is dedicated to the idea of peer review and has devoted much of its energy over the past year to increasing the effectiveness of its existing review system. It is the strong feeling of Iowa doctors that the practice of medicine can best be reviewed by medicine itself at the local level.

Peer review, as now implemented in existing Foundation programs and as proposed in other emerging programs, (1) brings under examination the reasonableness of the general rate of escalation in fees for physicians' services; (2) permits identification of the frequency and type of cases which exceed usual and customary "norms" established by the profession, and (3) offers the patient or third party the profession's judgment as to the value of the services rendered in questionable cases.

The Foundations now in operation have been described as catalysts, they have sought to stimulate new ways of assuring quality medical coverage in a given area. They have experimented with new methods of bringing health care to local populations and disadvantaged groups; they have worked with neighborhood health centers; they have been involved in experiments to improve the Medicare and Medicaid programs.

In brief summary the *Foundation for Medical Care* is an incorporated entity under the sponsorship of a medical society. It develops and encourages comprehensive medical care coverage and in so doing it emphasizes (1) free choice of physician and cost and (2) quality control through effective peer review.

In April of this year, the House of Delegates of the Iowa Medical Society was exposed formally for the first time to the *Foundation for Medical Care* mechanism. Those physician-delegates in the policy-making House of Delegates were told then that "the major motivational force behind . . . establishing foundations for medical care is a desire that the profession take direct responsibility for overseeing services provided by its members. . . ."

Acknowledging that such activity is already in progress in Iowa, the 1970 House of Delegates nonetheless (1) called for an in-depth feasibility study of an Iowa *Foundation for Medical Care,* (2) asked that a series of informational meetings be arranged for physicians to explain the structure of a *Foundation for Medical Care,* and (3) requested that specific recommendations regarding the creation of a Foundation be submitted to the House at the earliest possible time.

In making this multiple assignment, the House declared, "the Foundation approach might be the most practical and workable system for the medical profession to oversee services provided by its members, to fulfill the professional obligation of providing quality medical care as economically as possible and to assure that services are being properly utilized."

Phase 2 of the three-fold assignment begins this month with the first in a series of 13 regional meetings for Iowa physicians. The dates and sites for these informational meetings are noted below.

SCHEDULE OF INFORMATIONAL PROGRAMS ON FOUNDATIONS FOR MEDICAL CARE

Tuesday, September 8	Ottumwa (Ottumwa Country Club)
Thursday, September 10	Dubuque (Dodge House)
Tuesday, September 15	Creston (Berning Cafe)
Thursday, September 17	Sioux City (Sioux City Country Club)
Tuesday, September 22	Cedar Rapids (Roosevelt Hotel)
Wednesday, September 23	Spencer (Stubb's Ranch Kitchen)
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Tuesday, October 6	Davenport (Outing Club)
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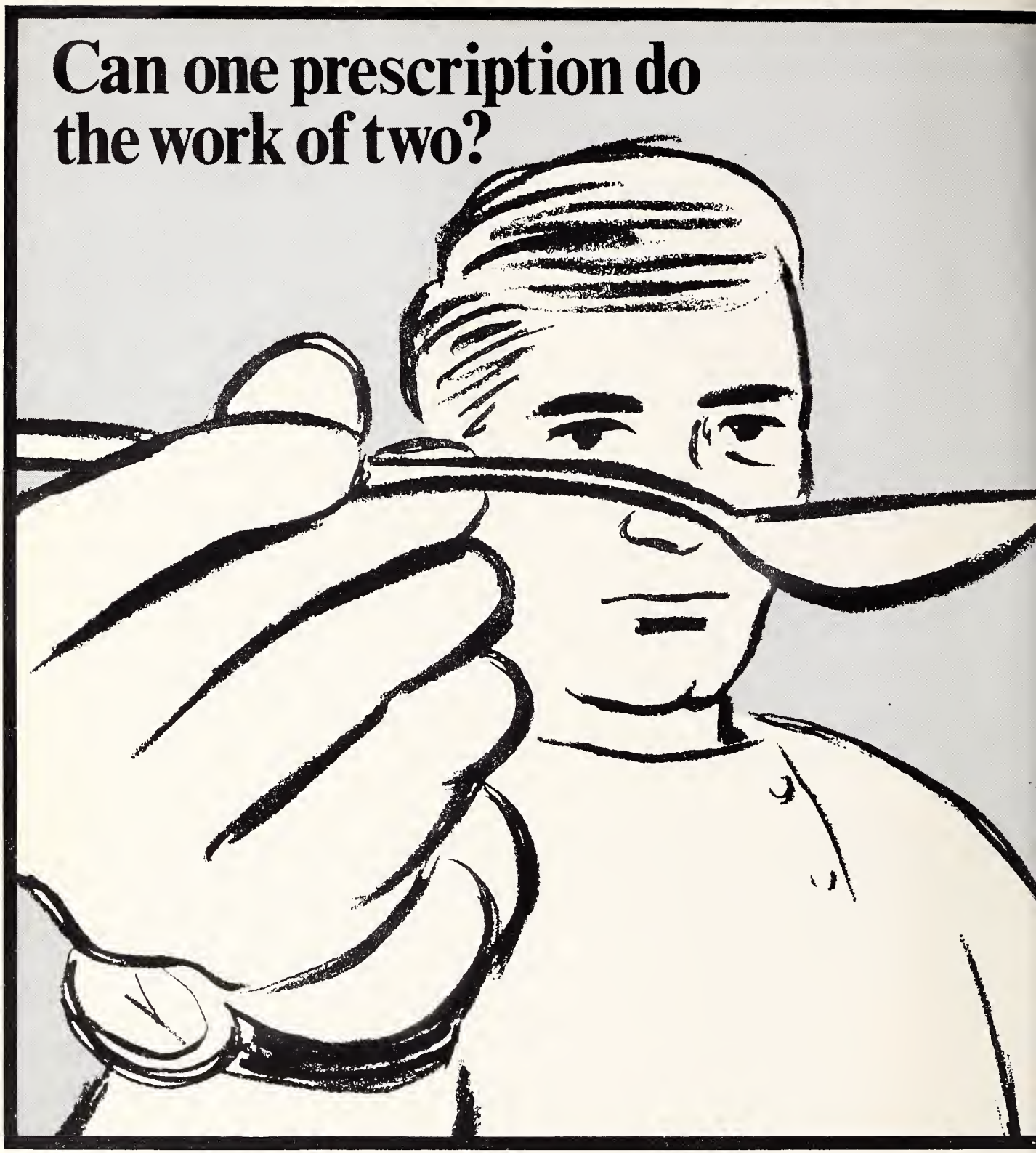
IN THIS ISSUE

- Therapeutic Abortions at University Hospitals, 1951-1969, With Emphasis on Current Trends—David W. Wetrich, M.D., and Lowell R. Hughes, M.D.
- Primary Adenocarcinoma of the Jejunum: Report of a Case—Hubert C. Peterson, M.D., and William J. Morrissey, M.D.
- Giant Calculus in a Diverticulum of the Male Anterior Urethra—A. Bekhrad, M.D., and D. A. Culp, M.D.
- Delayed Spontaneous Rupture of a Splenic Hemangioma—William W. Jones, M.D., and William A. Sybers, M.D.



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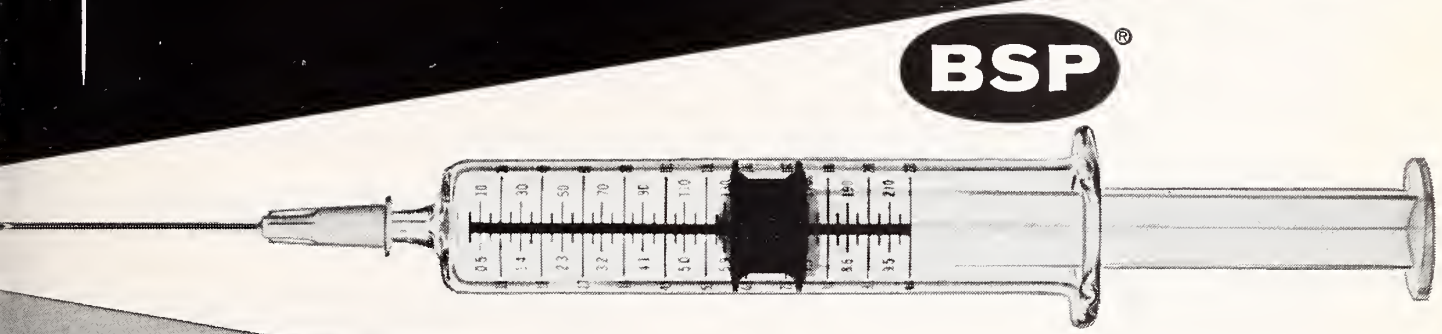
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Vol. LX OCTOBER, 1970 No. 10

CONTENTS

SCIENTIFIC ARTICLES

Therapeutic Abortions at University Hospitals, 1951-1969, With Emphasis on Current Trends
David W. Wetrich, M.D., and Lowell R. Hughes, M.D. 691

Primary Adenocarcinoma of the Jejunum: Report of a Case
Hubert C. Peterson, M.D., and William J. Morrissey, M.D. 696

Giant Calculus in a Diverticulum of the Male Anterior Urethra
A. Bekhrad, M.D., and D. A. Culp, M.D. 699

Delayed Spontaneous Rupture of a Splenic Hemangioma
William W. Jones, M.D., and William A. Sybers, M.D. 706

EDITORIALS

Cardiac Pacing 709

Digitalis Therapy 710

Impressed by American Youth 712

Diagnosing Venous Thrombosis 712

New Approach to Venous Thrombosis 713

SPECIAL DEPARTMENTS

Medical Meetings 681

President's Page 683

Iowa Medical Miscellany 684

Doctor's Business 688

In the Public Interest facing page 690

Journal Book Shelf 715

State Department of Health 717

Woman's Auxiliary News 720

American Association of Medical Assistants, State of Iowa, Inc. 724

Personals 725

Deaths 729

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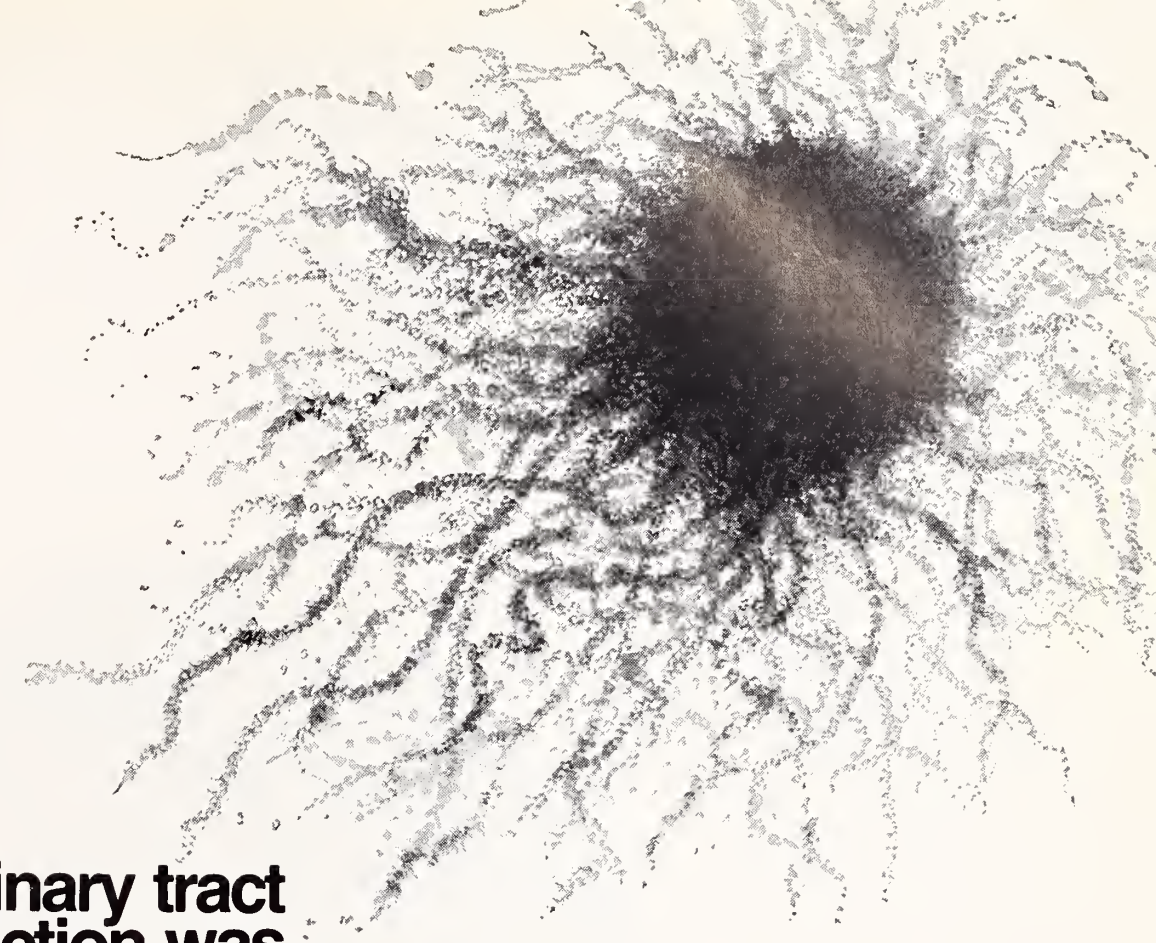
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A urinary tract infection was eliminated last week

ıtestinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

It doesn't let monilia begin where bacteria end. Declostatin® 300

Demethylchlortetracycline HCl 300 mg and
Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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depression state—combined tranquilizer-
antidepressant therapy could be indicated.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.



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Containing perphenazine and amitriptyline HCl

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

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INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; pregnancy; and in patients with known hypersensitivity to phenothiazines or amitriptyline. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least two weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response. Do not give concomitantly with guanethidine or similarly acting compounds since it may block the antihypertensive effect.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be increased.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Use with caution in patients with glaucoma and those with problems of urinary retention. Perphenazine can lower the convulsive threshold in susceptible individuals. It should be given with caution to patients with convulsive disorders. Dosage of the anticonvulsive agent may have to be increased. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients who have previously exhibited severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation. Significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypertension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; impotence; increased appetite and weight gain; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, stomatitis, blurring of vision, reversible dilatation of the urinary tract, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information, consult your MSD Representative or see the package circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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MEDICAL MEETINGS

CONTINENTAL U. S.

Sept. 30-Oct. 1	**30th Congress on Occupational Health sponsored by American Medical Association,** Century Plaza Hotel, Los Angeles.
Oct. 1-2	**Sixteenth Annual Symposium on School Health, sponsored by University of Kansas School of Medicine,** University of Kansas Medical Center, Kansas City, Kansas.
Oct. 2-3	**Cardiovascular Symposium sponsored by Great Plains Heart Association in co-operation with St. Louis Heart Association and AHA Council on Clinical Cardiology,** Stouffer's Riverfront Inn, St. Louis.
Oct. 4-9	**American Society of Plastic and Reconstructive Surgeons,** Century Plaza Hotel, Los Angeles.
Oct. 5	**Postgraduate Course on Medical Technology,** Cleveland Clinic, 2020 East 93rd Street, Cleveland.
Oct. 5	**Annual Meeting of American Academy of Ophthalmology and Otolaryngology,** Dunes Hotel, Las Vegas.
Oct. 5-7	**Three Days of Cardiology presented by American Heart Association Council on Clinical Cardiology in cooperation with Chicago Heart Association,** Passavant Memorial Hospital, Chicago.
Oct. 5-7	**Tenth Air Pollution Medical Research Conference,** Roosevelt Hotel, New Orleans.
Oct. 5-9	**Postgraduate Course on Basic Mechanisms in Internal Medicine sponsored by American College of Physicians,** Medical College of Virginia, Richmond.
Oct. 5-9	**Postgraduate Course on High Risk Infant Care sponsored by University of Colorado School of Medicine,** Denver.
Oct. 8-10	**American Association for Surgery of Trauma,** Drake Hotel, Chicago.
Oct. 11-12	**Postgraduate Course on How to Detect "Black Lung" Disease sponsored by American College of Radiology,** Chase Park-Plaza Hotel, St. Louis.
Oct. 12	**Oral Cancer Seminar sponsored by University of Colorado School of Medicine,** Denver.
Oct. 12-15	**Annual Meeting Indiana State Medical Association,** South Bend.
Oct. 12-16	**56th Annual Clinical Congress, American College of Surgeons,** Conrad Hilton Hotel, Chicago.
Oct. 12-16	**Interviewing, Data Gathering and Record Systems for the 1970's sponsored by American College of Physicians,** Michigan State University College of Human Medicine, East Lansing.
Oct. 15-17	**Teaching Workshop on Clinical Hypnosis and Hypotherapy sponsored by University of Minnesota and American Socicty of Clinical Hypnosis,** Pick-Nicollet Hotel, Minneapolis.
Oct. 17	**Kentucky State Meeting for Specialists in Internal Medicine sponsored by American College of Physicians,** Stouffer's Inn, Louisville.
Oct. 17-21	**Annual Meeting American Society of Anesthesiologists,** Americana Hotel, New York.
Oct. 17-22	**39th Annual Meeting American Academy of Pediatrics,** San Francisco Hilton, San Francisco.
Oct. 18-23	**Second Scientific Assembly of American College of Emergency Physicians,** Las Vegas.
Oct. 20-23	**Neurological Aspects of Internal Medicine,** Duke University Medical Center, Durham, North Carolina.
Oct. 21-23	**17th Western Cardiac Conference sponsored by Colorado Heart Association,** University of Colorado Medical Center, Denver.
Oct. 22-24	**Annual Fall Clinical Conference, Kansas City Southwest Clinical Society,** Hotel Muehlebach, Kansas City, Missouri.
Oct. 22-24	**National Congress on Health Manpower,** Palmer House, Chicago.
Oct. 25-29	**Second Annual Fall Scientific Assembly, American College of Chest Physicians,** Century Plaza Hotel, Los Angeles.
Oct. 25-31	**American College of Gastroenterology,** Statler Hotel, New York.
Oct. 26-28	**New Concepts in Basic and Applied Hematology sponsored by American College of Physicians,** Jefferson Medical College, Philadelphia.
Oct. 26-29	**Medical Audit and Continuing Education sponsored by University of Colorado School of Medicine,** Denver.
Oct. 26-30	**Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta, Georgia.
Oct. 27-30	**23rd Annual Meeting American Association of Blood Banks,** San Francisco Hilton, San Francisco.

Continuing Education Courses & Conferences

Please call or write Office of Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-4792.

Oct. 5-8	Intensive Coronary Care Management Course
Oct. 9 & 10	Care of Musculo-Skeletal Injuries
Oct. 14 - Apr. 28, 1971	Postgraduate Course in Psychiatry for General Practitioners and Other Physicians (meets weekly)
Nov. 6	Otolaryngology for Otolaryngologist
Nov. 6	Ophthalmology Clinical Conference
Nov. 20-21	In-House Conference for Practitioners
Nov. 20-21	Sports Medicine.
Nov. 24	Refresher Course on Cerebrovascular Disease

U. of I. College of Medicine

Oct. 27-31	**Congress of Neurological Surgeons,** Chase Park-Plaza, St. Louis.
Oct. 29-31	**Postgraduate Course on Gastroenterology sponsored by American College of Gastroenterology,** Statler Hilton, New York.
Oct. 30-31	**Second Annual Birth Defects Symposium sponsored by University of Florida College of Medicine,** Gainesville.
Oct. 29-Nov. 2	**Annual Meeting, Association of American Medical Colleges,** Hotel Biltmore, Los Angeles.
Nov. 2-4	**Clinical Reviews presented by Mayo Clinic and Faculty of Mayo Foundation,** Mayo Civic Auditorium, Rochester.
Nov. 2-4	**38th Annual Postgraduate Assembly of Omaha Mid-West Clinical Society,** Fontenelle Hotel, Omaha.
Nov. 2-13	**Postgraduate Course on Clinical Management and Control of Tuberculosis sponsored by University of Colorado School of Medicine,** Denver.
Nov. 2-13	**Postgraduate Course in Laryngology and Bronchoesophagology sponsored by Department of Otolaryngology,** University of Illinois Medical Center, Chicago
Nov. 4-6	**Postgraduate Course on Management and Care of Respiratory Insufficiency sponsored by University of Colorado School of Medicine,** Denver.
Nov. 5	**Postgraduate Course on Role of Nurse in Dealing With Emotional Problems of Patients, University of Nebraska Medical Center,** Yancey Hotel, Grand Island.
Nov. 5-7	**American Society of Cytology,** Biltmore, Los Angeles.
Nov. 6-8	**Congress of County Medical Societies Annual Meeting and Seminar on Private Practice,** Netherland Hilton, Cincinnati.

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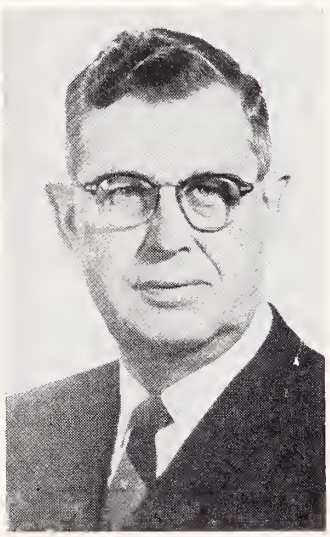
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Nov. 9-11	**Clinical Reviews presented by Mayo Clinic and Faculty of Mayo Foundation,** Mayo Civic Auditorium, Rochester.
Nov. 9-12	**Postgraduate Course in Internal Medicine sponsored by University of Kansas School of Medicine,** University of Kansas Medical Center, Kansas City, Kansas.
Nov. 9-13	**Postgraduate Course on Internal Medicine sponsored by Chicago Medical Society,** Knickerbocker Hotel, Chicago.
Nov. 9-20	**Postgraduate Course in Laryngology and Bronchoesophagology,** University of Illinois Medical Center, Chicago.
Nov. 10-11	**American Heart Association's Council on Arteriosclerosis,** Howard Johnson's Motor Lodge, Atlantic City.
Nov. 11-12	**Postgraduate Course on Diagnostic Procedures,** Cleveland Clinic Educational Foundation, Cleveland.
Nov. 11	**Postgraduate Cardiovascular Seminar sponsored by Scientific Councils of American Heart Association,** Shelburne Hotel, Atlantic City.
Nov. 11-12	**Postgraduate Course in Gastroenterology—Diagnostic Procedures sponsored by Cleveland Clinic Educational Foundation,** Cleveland.
Nov. 11-13	**Postgraduate Course on Genetics for the Internist sponsored by American College of Physicians, New York Hospital,** Cornell Medical Center, New York.
Nov. 11-14	**Fourth Annual Postgraduate Conference on Today's Hospital Problems: An Interdisciplinary Approach sponsored by Mound Park Hospital Foundation and University of Florida's J. Hillis Miller Health Center,** Tides Hotel and Bath Club, Redington Beach, Florida.
Nov. 13-14	**Sixth Annual Cornhusker Conference for Surgeons sponsored by University of Nebraska Medical Center,** Lincoln Country Club, Lincoln.
Nov. 12-15	**43rd Annual Scientific Sessions of American Heart Association,** Convention Hall, Atlantic City.
Nov. 13-14	**Postgraduate Course on Otolaryngology for Family Practitioners sponsored by University of Miami School of Medicine,** Sheraton-Four Ambassadors Hotel, Miami.
Nov. 16-20	**Postgraduate Course on Obstetrics and Gynecology sponsored by Chicago Medical Society,** Knickerbocker Hotel, Chicago.
Nov. 19-20	**Diagnostic and Therapeutic Problems in Practice of Pediatric Neurology sponsored by University of Nebraska Medical Center,** Lincoln.
Nov. 19-20	**Seminar in Obstetrics and Gynecology sponsored by University of Florida College of Medicine,** Gainesville, Florida.
Nov. 19-21	**Symposium on Battered Child sponsored by University of Colorado School of Medicine,** Denver.
Nov. 20-21	**Current Concepts in Pathogenesis and Therapy of Kidney Disease sponsored by Upper Midwest and Wisconsin Kidney Foundation,** University of Wisconsin, Madison.
Nov. 20-21	**Workshop on Doctor and His Changing Community sponsored by Institute of Medicine of Chicago,** Ambassador West Hotel, Chicago.
Nov. 27-28	**Conference on Radiology in Otolaryngology and Ophthalmology,** University of Illinois Medical Center, Chicago.
Nov. 29-Dec. 2	**Clinical Convention, American Medical Association,** Boston.

ABROAD

Oct. 5-7	**Postgraduate Course on Recent Advances in Gastroenterology,** Institute National de Nutrition, Mexico.
Oct. 18-Nov. 12	**Eleventh International Congress of Internal Medicine sponsored by American College of Physicians,** New Delhi.

President's Page



The over-worked Iowa physician is a victim of the "doctor-shortage." Consequently he is most interested in medical education and he is curious to know about contemplated changes which may alleviate his dilemma.

In Iowa we are fortunate to have excellent leadership in medical education from men like Drs. Hardin, Eckstein and MacQueen. The officers of the Society have had the finest cooperation from these individuals and other members of the teaching staff. Their efforts have been forthright and expeditious.

As would be the case anywhere, some programs have been instituted and some decisions made with which we have not totally agreed, but in my 16 years of Society work the lines of communication with the U. of I. College of Medicine have always been wide open.

In these times of change, innovation, experimentation and economic stress there is even more need for a close partnership between the practitioner and the educator. I am sure this will come about.

President

IOWA MEDICAL MISCELLANY

The Month in Washington has been a regular feature in the JOURNAL for many years. TMIW has sought to summarize important health care developments in the nation's capital. Our impression is that it has served well. However, other periodicals, e.g., THE AMERICAN MEDICAL NEWS, which Iowa physicians receive regularly cover the Washington scene much more comprehensively. For this reason, we have chosen to abandon the long-standing *Month in Washington* feature and to substitute for it a collection of Iowa-flavored news briefs. We plan to capsulize Society activities for interested members. Your comments and reactions are welcome.

* * *

AMA President Walter C. Bornemeier, M.D., will be in Des Moines October 30 to address the national convention of the American Association of Medical Assistants. IMS President J. H. Sunderbruch, M.D., will also be a convention speaker. Between 700 and 800 medical assistants from about the country are expected to attend the four-day meeting (October 28-31) at the Hotel Fort Des Moines. The Iowa Chapter of AAMA is host for the parley.

* * *

Better than 150 Iowa physicians have been briefed on the Foundation for Medical Care concept in the first four regional meetings. The Society-sponsored series of 13 meetings includes October stops in Council Bluffs (1st), Davenport (6th), Burlington (8th), Mason City (13th) and Boone (15th). Society President J. H. Sunderbruch, M.D., and Board Chairman K. E. Lister, M.D., are presenting the Foundation story at each session. The informational meetings were requested by the 1970 IMS House of Delegates.

* * *

The second statewide Conference on Drug Abuse of the Iowa Health Council will occur October 7 at the Veterans Auditorium in Des Moines. Speakers include Governor Ray; Darold A. Treffert, M.D., Superintendent, Winnebago State Hospital, Winnebago, Wisconsin, and Phillip Levine, Ph.D., the Governor's Consultant on Drug Abuse Programming. Better than 1,500 students, educators, parents, clergymen, social workers and others attended the 1969 conference.

* * *

C. E. Radcliffe, M.D., Iowa City, was named president-elect of the Iowa Health Council at its annual meeting in September. Nine organizations, including the Iowa Medical Society, comprise the IHC.

* * *

"Lack of communication is the main reason for discord and misunderstanding between medical student and private practitioner." So says Dennis Brightwell, editor of THE SAMA NEWS, *a magazine published 10 times a year by the Iowa Chapter of the Student American Medical Association. To break down any communications barrier, Editor Brightwell invites Iowa physicians to subscribe to* THE SAMA NEWS. *A one-year subscripton is $3.50. Send orders to Circulation Manager,* THE SAMA NEWS, *University of Iowa College of Medicine, Iowa City, Iowa 52240.*

* * *

Sixty-two medical students have participated in the Iowa Medical Tuition Loan Plan since it was instituted in 1967. The state program provides loans to medical and osteopathic students who will agree to practice general medicine in Iowa for at least five years after completion of training. Of the 62 medical participants, 45 are still in school, 11 are interning, 3 are in military service, 2 are in practice in Iowa, and 1 is in an uncertain status. There have been 95 osteopathic participants in the program. The next Iowa General Assembly will be asked to appropriate $330,000 to continue the program.

* * *

October Society meetings include: Committee on Alcoholism—October 14 (at Independence Mental Health Institute); Committee on Medical Education and Hospitals—October 17 (in Iowa City); Board of Trustees—October 20; Judicial Council—October 20; Executive Council—October 21.

* * *

Applications for 1971-72 medical research grants are being accepted through November 2 by the Iowa Thoracic Society. Covered research areas include tuberculosis, respiratory physiology and associated fields. ITS grants are made to nonprofit institutions to support a particular investigator. Applications are also being accepted for advanced clinical training. Information is available from the ITS executive director, 1818 High Street, Des Moines 50309.

* * *

Tuesday, November 3 is Election Day!! VOTE. See the In the Public Interest section for more on the election.

C. E. Denser, M.D., Des Moines, has been named a member of the American Medical Association's Quackery Committee. Dr. Denser now serves on the IMS Quackery Committee.

* * *

Des Moines attorney Allen Whitfield is now heading a Task Force on Health Care Delivery Systems for the United States Chamber of Commerce. The Society has provided informational materials to Mr. Whitfield and has offered any assistance which may be desired.

* * *

At its September meeting the IMS Board of Trustees expressed concern over the receipt by Iowa physicians of several communications calling attention to out-of-state abortion facilities. The Trustees noted the condemnation of this practice by the AMA Judicial Council.

* * *

Richard Rix has resigned as executive director of the Health Planning Council of Iowa and will assume a similar post in Portland, Oregon. Rix has served as HPCI executive director approximately three years. The Iowa Medical Society was instrumental in establishing this voluntary organization which seeks to stimulate sound health care planning in the state.

* * *

With concurrence from the Board of Trustees, Society President J. H. Sunderbruch, M.D., is now constituting a study committee to evaluate with representatives of the Iowa Chapter, American Institute of Architects, the merits of a joint and ongoing analysis of hospital and health facility design for the benefit of both professions. This action is in line with action taken by the 1970 House of Delegates.

* * *

Two fall scientific programs arranged by the Surgical Service of the Veterans Administration Hospital in Des Moines are open to interested Iowa physicians.

On October 30 a lecture on the "Nutritional Care of Surgical Patients" will be presented by Edward E. Mason, M.D., professor of surgery at the U. of I. College of Medicine.

Diverticulitis will be the subject of a presentation by R. Kennedy Gilchrist, M.D., on November 5. Dr. Gilchrist is professor of surgery at the University College of Medicine and Rush Medical College, Chicago.

Both lectures will be at 1:15 p.m. in Room 423 at the Veterans Administration Hospital in Des Moines.

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Average dose per injection: One or two 10 ml. injections of Calphosan each week for the first four or five weeks, and on a when-needed basis thereafter.

Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

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So, to help them both get through
menopause, remember Menrium.



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Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

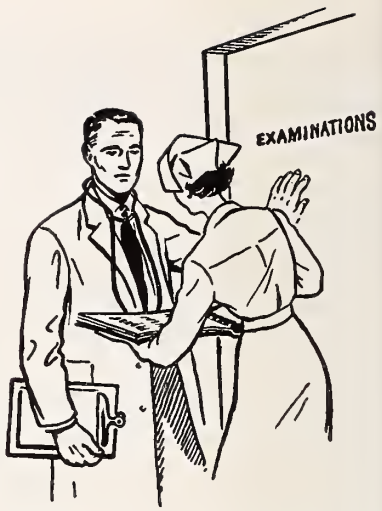
With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

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5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

THE DOCTOR'S BUSINESS



Personal Financial Records

LARRY E. LEAVERTON
Des Moines

The successful physician with a well managed practice usually has his personal affairs in order. Right? Wrong. Some doctors whose offices are models of efficiency have difficulty locating a receipt to substantiate a non-professional tax deduction or the cost basis of a stock purchase.

Problems of incomplete personal financial records come up at income tax time, of furnishing financial information to a lending institution, to an attorney in order to prepare a will, or to a financial advisor in discussing an estate problem. This problem is most evident with the doctors in partnerships and groups. The solo practitioner can align his non-professional income and expenses with his practice records. The doctor in group practice needs a system apart from the practice.

Family records can be set up similarly to your office systems. A simple basic system would include a personal checkbook with stubs or a running register of checks drawn, replenished by one check each month from the business account. Checks for obviously personal items such as food, clothing, household expenses, personal entertainment, personal gifts, and expenses on personal auto may simply be marked "personal." Checks for tax deductible items, such as interest expense, contributions, tax payments, investments, or savings should normally be paid through the business account. If this is not possible or practical they should be clearly marked on the stub or register so these items can be listed for tax purposes. As with your office records, an unpaid bill file and a paid bill file are necessary. As the bills are paid they will be filed in the same order as the checks written. After the end of the year the paid bill file can be emptied and bundled up for storage along with the 12 months' bank statements and canceled checks. If later retrieval is necessary, the records can be located by the date order.

Other filing classifications for the home filing system would be: Income tax returns, real estate, investments, medical and personal organizations, personal projects pending, a file containing a list of credit cards carried, and a list of the inventory of your safe deposit box.

Every family should have a safe deposit box. Usual contents would be: Biographical data, birth certificates, marriage certificates, military papers, insurance policies, a copy of your wills, stocks and bonds. Copies of documents in the bank box can be made for the home files.

How long should personal files be kept? These are general guidelines which will suffice in most situations:

Bank Statements and Canceled Checks—filed by month, then by year. Five to seven years, except for tax deductible items. The statute of limitations normally for Federal tax audit purposes is three years from the filing date but in cases such as fraud it is unlimited.

Bank Account Passbooks—Save until account closed. List of accounts and numbers in safe deposit box.

Paid Bills—File in date order. Five years' retention is generally sufficient.

Credit Cards—Maintain a list by firm and number for ready access in event of loss.

Insurance Policies—List in files until expiration—policies in safe deposit box.

Biographical Data (includes birth certificates, marriage certificates, divorce decrees, military papers, etc.)—keep originals in safe deposit box—photocopies may be kept in home files.

Memberships—File by organization.

Real Estate Deeds, Records of Improvements—Keep in safe deposit box with list in home file.

Stocks and Bonds—Records of ownership dates and cost basis in home files, certificates in safe deposit box.

Income Tax Returns—File by year. Keep indefinitely.

Wills—Copy in home file, original signed copy in safe deposit box, signed copy with lawyer.

For proper management of personal finances complete financial records are necessary. The goals should be: Protection of vital records, a filing system that permits quick retrieval of records and a retention schedule that holds down the amount of paper accumulated.

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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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Scientific Articles

Therapeutic Abortions at University Hospitals, 1951-1969, With Emphasis on Current Trends

DAVID W. WETRICH, M.D. and
LOWELL R. HUGHES, M.D.
Iowa City

Abortion is a topic of great current interest with 13 states having liberalized their abortion laws in the past three years and many other legislatures, including Iowa's, considering changes. The recent court decisions in California and the District of Columbia, as well as the results of recent opinion polls, are further evidence of the tremendous thrust from many directions for more liberal use of therapeutic abortion. Although the Iowa abortion law has not changed since 1843, these pressures for reform have had a profound effect on the therapeutic abortion experience at University Hospitals. This presentation will analyze the experience at University Hospitals since 1951. Abortion has many highly controversial elements, i.e., moral, religious, legal-judicial and medical. It is not the purpose of this presentation to attempt to analyze the controversial aspects of the subject.

THERAPEUTIC ABORTION COMMITTEE

Patients referred to the Department of Obstetrics and Gynecology for consideration for therapeutic abortion have been interviewed and examined by a physician in the Department to confirm the pregnancy and to discuss the patient's abortion indications and possible alternative measures. The patients have been seen by a consultant in the appropriate hospital department, e.g., cardiology if an abortion is to be done for heart disease. All patients with psychiatric indications, or rape or incest indications, and some with fetal indications have been seen by the Department of Psychiatry. Following this, and assuming the patient and her husband, if married, or parents, if a minor, indicate a desire for abortion, the case has been presented to the Therapeutic Abortion Committee for approval or rejection. This Committee has been composed of all members of the full time staff of the Department of Obstetrics and Gynecology. The Committee has acted by majority vote and has rather consistently approved the recommendations of the consulting physicians. The recommendations of the consultants have been rejected on a few occasions and occasionally the advice of another consultant has been requested. With Committee approval the abortion has been accomplished by a physician in the Obstetrics and Gynecology Department. Prior to 1960 no such committee existed and approval was

Dr. Hughes is an associate professor and Dr. Wetrich is a resident in the Department of Obstetrics and Gynecology at The U. of I. College of Medicine.

granted by the head of the Department of Obstetrics and Gynecology after appropriate consultation. As of February 1970, the composition of the Therapeutic Abortion Committee was changed to include three obstetrician-gynecologists, one resident in obstetrics and gynecology, one psychiatrist and one consultant from the department most directly associated with the patient's problem. Also the Committee includes a representative of the hospital administration as a non-voting member.

NUMBERS OF THERAPEUTIC ABORTIONS

From 1951 through 1969 there were 149 therapeutic abortions done at University Hospitals. An earlier report of the experience, 1926 through 1950 by Moore and Randall,[1] covered 137 therapeutic abortions and parts of this earlier analysis will be alluded to later. Table 1 identifies the number of abortions done each year with a breakdown by indications. The 1926-50 figures are averages per year for that period of time. An upward trend in total numbers done each year begins in 1964-65 with a striking year by year increase starting in 1967 and continuing through 1969 to an all time high of 35 therapeutic abortions in one year. The table reveals the source of these trends by indications.

TABLE 1

YEARLY TOTALS BY INDICATIONS

Year	Medical	Psych (2)	Fetal	Rape and Incest	All
1926-50[1]	5.0	.36	.08	0	5.4
1951	2	2	0	0	4
1952	6	1	0	0	7
1953	2	2	0	0	4
1954	2	3(1)	1	0	6
1955	2	3(1)	0	0	5
1956	3	1	1	0	5
1957	4	1	1	0	6
1958	3	0	1	0	4
1959	2	0	1	0	3
1960	3	2	1	0	6
1961	1	0	2	1	4
1962	1	0	1	0	2
1963	1	0	0	0	1
1964	3	0	7	2	12
1965	2	3(2)	3	1	9
1966	0	5	0	0	5
1967	1	6(2)	3	1	11
1968	3	15(1)	0	2	20
1969	8	21(4)	4	2	35
1951-69 Total	49	65	26	9	149

1. 1926-50 figures are yearly averages for that period. The 1951-69 figures are numbers per year.

2. The figures in parentheses are cases with psychiatric indication that also included rape or incest as part of the history. These cases in parentheses are included in the psychiatric figures for each year. They are not duplicated in the rape and incest column.

INDICATIONS

Medical indications accounted for 49 or 33 per cent of the 1951-69 abortion total. This contrasts with the 1926-50 era when medical indications comprised 92 per cent of the cases. The 49 medical indications from 1951-1969 can be subdivided as follows: 16 hypertensive disease and/or renal failure, 12 cardiac disease (5 rheumatic, 3 congenital, 1 both rheumatic and congenital, 2 kyphoscoliotic, and 1 hypertensive), 5 respiratory disease (3 post-polio weakness, 1 intrinsic asthma with emphysema, 1 cystic fibrosis), 5 second trimester pregnancy hemorrhage, 5 malignancy (2 cervix, 2 brain, 1 breast), 3 tuberculosis (last 1952), and 3 miscellaneous. Table 1 suggests no real trend in therapeutic abortions done for medical reasons except that the 8 done in 1969 seems unusually high by comparison with other years.

Fetal indications accounted for 26 or 17 per cent of the 1951-1969 abortions. In the 1926-1950 era there were only 2 or 1.5 per cent. The fetal indications can be subdivided as follows: 12 rubella (7 in 1964), 4 repeated stillborns due to Rh disease, 4 cancerocidal agents to mother (2 external radiation, 1 Cytoxan, 1 therapeutic I^{131}), 4 hereditary or familial disease (1 cerebellar degeneration, 1 Friedreich's ataxia, 1 cardiac and extremity deformities, 1 syndactyly), 1 rubella vaccine, 1 three consecutive meningomyelocele births. A review of Table 1 shows a gradually increasing trend beginning in 1954. Notable is the peak of 7 in 1964 all being done for rubella.

Psychiatric indications accounted for 65 or 44 per cent of the 1951-1969 abortions. In the 1926-1950 era 6.5 per cent of the indications were psychiatric. A psychiatric indication in most cases implies that the psychiatrist who interviewed the patient felt there was a threat of patient suicide. These patients were felt to have reactive depressions or a likelihood of exacerbation of chronic manic-depressive or

schizophrenic illness because of the stress of pregnancy. Obviously other psychiatric diagnoses were also included in many cases. Table 1 reveals a markedly accelerating increase in psychiatric indications over the past 3 or 4 years. This more than any other factor accounts for the recent increase in therapeutic abortions at University Hospitals.

Rape and incest accounted for 9 or 6 per cent of the abortions done 1951-1969. There were none in the 1926-1950 series. In addition 11 of the abortions done for psychiatric reasons included rape or incest as part of the history. These are indicated in Table 1 by the bracketed numbers. Of these 20 cases in which rape or incest was part or all of the indication, 16 involved rape and 4 incest. In almost all cases done for rape and incest, even where there was felt to be no suicidal risk, the psychiatrists felt there would be grave impairment of the patients' mental health if the pregnancies were not interrupted. Table 1 reveals a definite increase in abortions done for rape and incest indications over the past 6 years. These same trends appear to be continuing into 1970.

METHODS

Of interest are trends in the methods used in accomplishing the abortions. This is depicted in Table 2. There has been a definite increase in dilatation and curettage termination, apparently due to the earlier stage of gestation at which abortion is being considered. Hysterotomy has disappeared as a method of terminating the more advanced pregnancies and has been replaced by hysterectomy or intraamniotic-hypertonic saline injection. Where sterilization is being accomplished tubal ligation has been increasingly replaced by hysterectomy which simultaneously accomplishes abortion and sterilization. However in selected cases, hysterotomy combined with tubal ligation is far easier than intraamniotic saline followed by tubal ligation.

REFERRAL PATTERNS

The source of patients being aborted for the 10-year period 1960-1969 has been analyzed and is depicted in Table 3. This reveals that the majority are referred by physicians around the state but that a significant number are self referred (particularly for psychiatric reasons).

TABLE 2

METHOD IN PERCENTAGE

	1951-55	1956-60	1961-65	1966-69
D&C	23	25	46	52
Hysterotomy	65	54	18	0
Hysterectomy	12	13	11	23
Intraamniotic saline	0	0	25	25
Pitocin	0	8	0	0
Tubal ligation	50	63	11	8
Sterilized	62	76	22	33

It is clear to us that many patients are referred because we are willing to consider abortions for psychiatric, fetal, or rape and incest indications. There are no recorded figures on therapeutic abortions done elsewhere in the state but many patients are referred to us from larger cities around the state because the physicians are reluctant to perform the abortions in their own communities. This reluctance would appear to stem from a fear of criticism by the public or by their colleagues or a fear of legal reprisal. It would appear that University Hospitals are the major referral center in the state for therapeutic abortions, particularly for the more controversial psychiatric, fetal, and rape and incest indications. We feel that with adequate consultation therapeutic abortion committees could function in some of the

TABLE 3

REFERRAL PATTERNS—ALL CASES
1960-69

	Number	Per Cent
Total number	105	
Self referral	19 (14 pysch, 3 rubella)	18
Referral by another hospital department	12 (6 from psychiatry)	11
Referral by outside physician	74	74
Patients of private financial status from a city with medical and consultative resources that would have enabled abortion locally	35 (22 psychiatric, 12 fetal or rape or incest, 1 medical)	33

TABLE 4

	1951-55	1956-60	1961-65	1966-69
Total number	26	24	28	71
Average age	30.1	30.0	27.2	27
<20, >35 yrs.	27%	17%	39%	49%
Nulliparous	35%	17%	32%	42%
Unmarried	35%	13%	39%	58%
Indigent	38%	17%	14%	24%
Sterilized	62%	76%	22%	33%

larger communities with no more jeopardy than we incur.

OTHER TRENDS

Table 4 shows other trends in our patients. In recent years they have tended to be more outside the 20 to 35 year age range, more often nulliparous, more often unmarried, and less often sterilized as might be anticipated from our shifting indications.

PSYCHIATRIC INDICATIONS

Since the most dramatic increase in abortions has occurred in the area of psychiatric indications a special analysis here seems in order. As previously noted there was felt to be a threat to the mother's life in terms of a suicidal risk in almost all the cases. The degree of risk was felt to be definite but varied from slight to marked with most being moderate. There is disagreement even among psychiatrists as to the risk of suicide in pregnant depressed patients and as to the effect of therapeutic abortion in these patients. But in general our psychiatrists have felt that pregnant women with reactive depressions do on occasion commit suicide and termination of pregnancy reduces this risk. Two patients in the series of 47 psychiatric abortions done since 1966 attempted suicide during their pregnancy prior to the abortion and another two were known to have made suicide attempts within 4 months after their abortions. In addition, in the past 4 years, two women from Iowa City are known to have taken their lives by suicide under the emotional stress of pregnancy. These latter two women are not included in this reported series as they were not aborted. Of course it is impossible to analyze what would have happened to these 47 patients had an abortion not been performed.

TABLE 5

PSYCHIATRIC ABORTIONS
1966-69 (47)

	Number	Per Cent
<20, >35 yrs.	24	51
Nulliparous	20	43
Unmarried	32	68
Unmarried or >35	41	87
Referrals:		
Self referral	13	28
Referral by psychiatry department	2	4
Referral by outside physician	32	68
Patients from Iowa City-Coralville	14	30
Patients of private financial status referred from a city with psychiatric and medical resources to enable abortion locally	18	38

Several reports are in the literature regarding the psychiatric adjustment of patients after therapeutic abortion including one by Kretzschmar and Norris of our own institution.[2] Most of these studies, including our own, indicate only a very few of these patients have serious long term remorse or guilt over having been aborted. Again, it is impossible to say whether their adjustment would have been better or worse had abortion not been done.

Table 5 indicates other features of our therapeutic abortions for psychiatric indications for the past 4 years. Sixty-eight per cent were unmarried and 87 per cent were either unmarried or over 35. Since the pregnant out-of-wedlock woman and the older woman with several children are the two groups most likely to seek criminal abortions (these are estimated to outnumber therapeutic abortions 100 to 1), it would appear that in doing abortions for psychiatric reasons we are serving the same group the criminal abortionist serves but in much smaller numbers. Many of the patients aborted for psychiatric reasons freely admit they are seriously considering criminal abortion as a solution to their problem. The obvious truth is that patients, who have reactive depressions and who commit suicide because of pregnancy, are usually depressed because of the effect of an unwanted pregnancy on a personality that is none too strong in the first place. The question is: Should they be denied

help because they somewhat resemble the large number of women with unwanted pregnancies? Because of the strong social factors in these cases, the psychiatrists are in the very unenviable position of trying to judge suicidal risk without being biased by considerations such as the ability of the woman to perform as a mother or by her determination to seek a criminal abortion. It is little wonder that as a group, the psychiatrists in our country are most highly in favor of changing our laws to allow abortion on request.

The referral pattern of our recent psychiatric abortions is also depicted in Table 5. It can be seen that a substantial number are self referred and are from the immediate area. Furthermore, it is again apparent that other physicians around the state are requesting us to do abortions that they are reluctant to do in their own communities.

WHY THE RECENT INCREASES

The reason for the recent increase in the numbers of abortions for all indications has not been elaborated on as yet. Are more people going to physicians requesting abortions? Are physicians more willing to consider the possibility of therapeutic abortion? Are physicians in University Hospitals, including our Department, our psychiatrists and other consultants, more inclined to recommend and approve abortions? The answer to all of these questions would appear to be yes. There have been no records kept of the number of abortion requests turned down by the Therapeutic Abortion Committee, but it is clear that there has been a marked increase in the number of requests being presented to this Committee and a marked increase in referrals of patients who are requesting therapeutic abortion. Have the attitudes of physicians within our hospital changed? Table 6 shows a trend analysis of certain factors, namely, patient age, marital status, and nulliparity, that are correlated with social factors making a pregnancy unwanted. It is noteworthy that for both psychiatric and medical indications there seems a trend toward a more liberal use of therapeutic abortion as a solution to social problems which are distressful to the patient. Factors such as pregnancy out-of-wedlock, the unwanted pregnancy in the older multipara, and the difficulties with

TABLE 6

PATIENT CHARACTERISTICS BY INDICATION AND TIME PERIOD

	Psychiatric		Medical	
	1951-65	1966-69	1951-65	1966-69
Number	18	47	29	13
<20, >35 yrs.	33%	51%	34%	62%
Nulliparous	33%	43%	17%	38%
Unmarried	44%	68%	28%	23%

child care by the chronically ill mother have always played a role in the decision to do therapeutic abortions for indications shown as medical and psychiatric; it appears now that these factors are playing an increasing role.

At all levels then, including patients, referring physicians, our consultants and our own Department, there seems to be less and less reluctance to consider, recominend, and perform therapeutic abortions. The reasons for these shifting attitudes would seem influenced by the snowballing effects of various forces over the past decade including the European Thalidomide disaster of the early 1960's, the rubella epidemic of 1963-64, and the subsequent legal problems of physicians over doing abortions for fetal indications. The widespread debate of the problem in many state legislatures, with liberalized abortion laws passed in 13 states over the past three years, and the two judicial decisions in the past year sweeping away local restrictions on abortion, has had a profound impact. Our state legislature has been debating the problem in its recent sessions, and public opinion polls in Iowa indicate widespread public support for more liberal laws. In addition to changing attitudes toward abortion there have been shifting attitudes toward sexual expression in our society and this is most graphically dramatized by the more than doubled rate of illegitimate pregnancies in Iowa in the last decade. It would appear that all these forces share in bringing about the change in attitudes which has resulted in the marked increase in therapeutic abortions in our institution.

WHERE DO WE GO FROM HERE

This discussion has been largely an analysis of what has happened and why. We will refrain from any discussion of what should be

done in the way of legislative changes. This is controversial even in our own Department although many favor liberalizing the laws.

One problem that is arising and which will be many times more acute if and when our laws are changed is the matter of who will do all the abortions that will be requested. It seems clear from our experience at University Hospitals in recent years and also from the experience in the states where the laws have been liberalized recently that many physicians, although they may approve of the changes in the laws, are reluctant to become involved in doing abortions. The few that are willing to do the abortions are swamped with referrals from other physicians who are equally capable of handling the problem. Certainly it must always be the prerogative of a physician or hospital not to do abortions if their conscience so dictates. Nevertheless, in states where the laws have been liberalized the willingness to let somebody else do the abortions has produced an overwhelming case load in certain university teaching hospitals and has resulted in a breakdown of the student and resident teaching program. These may just be growing pains as new legislation gains acceptance but to make legislation workable physicians who want their patients to have abortions will have to participate in this medical activity.

At present we do not consider the case load intolerable at University Hospitals but it is certain that if our state laws are liberalized we are not going to be able to continue to do the bulk of the therapeutic abortions for the whole state. We certainly will continue to provide indigent care including indicated abortions but we feel that others must share the load in providing indicated abortions for the non-indigent.

Gratefully acknowledged is the help of Linda Helmke and Judith Blommers in collecting the above data and preparing the manuscript.

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Primary Adenocarcinoma of the Jejunum: Report of a Case

HUBERT C. PETERSON, M.D., and
WILLIAM J. MORRISSEY, M.D.
Des Moines

CARCINOMA OF THE SMALL INTESTINE has always been considered comparatively rare. It was found by Cunha and Day[1] to comprise almost 3 per cent of all carcinomas. Other authors, after reviewing the literature,[2, 3] have found that carcinoma of the intestine accounts for between 0.029 and 6 per cent of all gastrointestinal malignant lesions, with a generally accepted average being 3 per cent. Of this 3 per cent, less than 1 per cent have been carcinomas of the jejunum,[1] so that, relatively speaking, it can be said that this malignancy is indeed rare.

Numerous theories have arisen to explain the decided rarity of carcinoma occurring in the 20 or 50 feet of intestine between the pylorus and the ileocecal valve. Three factors most frequently cited include: 1) The fluidity of the fecal stream and the rapidity with which it passes a given point decreasing the friction and the amount of time possible carcinogens are in contact with the mucosa. 2) Alkalinity is frequently mentioned, but the influence it exerts against carcinogenesis, if any, remains unclear. 3) Freedom of stasis and accompanying irritation produced by mechanical hindrances such as kinks and flexures. Another interesting question brought up by Mech[4]

Dr. Peterson is a resident in pathology at Mercy Hospital in Des Moines. Dr. Morrissey is in the private practice of internal medicine in Des Moines.

concerns the effect that active enzymes might have on the possible carcinogen.

The average age of patients with jejunal lesions in the series of Pridgen, Mayo and Docherty[3] is 47.8 years, although a larger number are in the fifth and sixth decades. The male to female sex ratio is approximately 2:1 in carcinoma of the jejunum, while the number of patients of each sex with carcinoma of the ileum is almost equal.

CASE REPORT

A white woman, age 83, was admitted to Mercy Hospital on June 23, 1968, because of nausea and vomiting of approximately 10 days duration. Vomiting usually occurred 1-3 hours after eating and was associated with vague, poorly localized abdominal discomfort. No definite pain was described, but the discomfort was relieved by vomiting. A similar episode occurred about six months previously, but spontaneously resolved after several days. Occasional bouts of nausea and vomiting followed, but without definite relation to food intake. Other complaints included occasional dyspepsia, anorexia, and progressive weakness. There were no complaints referable to the cardiorespiratory, genitourinary, or neuromuscular systems. In addition to the usual childhood diseases, she had an appendectomy and a hernia repair. Several ribs were fractured in an accident. She gave no history of allergies or familial disease.

The patient was well developed but poorly nourished, in no acute distress. Her temperature was 99.0° F., respirations 20, pulse 80, and blood pressure 140/80 mm. of mercury. Examination of the heart and lungs revealed no significant abnormalities. The abdomen was flat and elastic with no tenderness or muscle guarding. In addition, no palpable masses or distention were noted. There were no enlarged lymph nodes.

Initial laboratory studies included a hemoglobin of 12.6 gm. and hematocrit of 39 per cent. Results of urinalysis revealed a specific gravity of 1.023, with a small amount of acetone, and 5-10 WBC's per high power field. A urine culture revealed gram negative enteric bacilli. The blood urea nitrogen was 25 mg. per cent. A flat and upright film of the abdomen showed a moderate amount of small

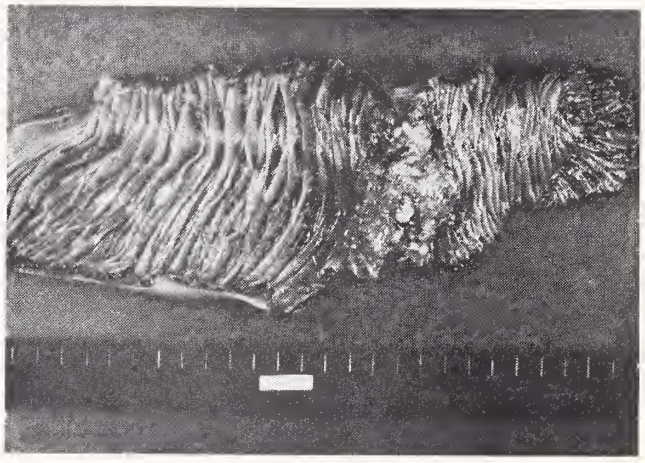


Figure 1. Marked dilatation of proximal portion of jejunum.

intestinal gas. A small amount of large bowel gas was also present. There was no evidence of free air under the diaphragm. An upper GI series revealed a rather poorly outlined stomach. Considerable ballooning of the small bowel, apparently jejunum, was seen, with findings suggestive of intermittent or incomplete obstruction in the midjejunum. At 3½ hours the dilated jejunum was again noted, with barium also being seen in the ileum. An oral cholecystogram failed to reveal a gall bladder shadow of sufficient density for diagnostic purposes.

The pre-operative diagnosis was partial small bowel obstruction. An exploratory laparotomy was performed on July 10, 1968; an annular obstructing lesion was found 40 cm. distal to the ligament of Treitz. A frozen section diagnosis was adenocarcinoma. Further investigation revealed several small regional nodes, the liver and the remainder of the peritoneal cavity being free of apparent metastases. The segment of jejunum containing the adenocarcinoma was resected with an appropriate wedge of mesentery (Figure 1). An end-to-end anastomosis reestablished small bowel continuity. An incidental ovarian cyst was also removed and old surgical adhesions were lysed in the right lower quadrant. Her post-operative recovery was complicated by ileus, abdominal distention, and vomiting, but these responded to nasogastric suction and intravenous fluid.

The surgical specimen consisted of a segment of jejunum 26 cm. in length, with accompanying mesentery and lymphatics. In the central portion of the segment there was an annular fungating lesion rising approximately 2 cm.



Figure 2. A close-up view of jejunal adenocarcinoma.

above the mucosa, the circumference in this area being reduced to 3 cm. (Figure 2). The linear extension of involvement measured 3 to 4 cm., with the underlying serosa being thickened and bound down for a length of 0.5 to 1 cm. In the attached wedge of mesentery several nodules were palpated.

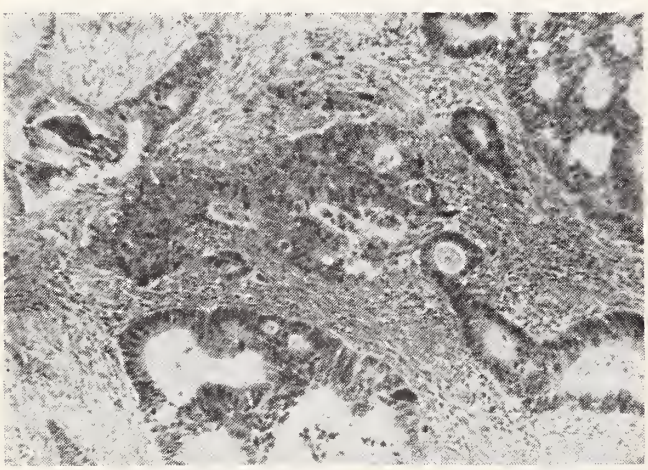
Microscopic study revealed an abrupt cytologic change from normal mucosa to an anaplastic adenocarcinoma with abundant mucinous material. The entire wall of the intestine was involved, but the serosal fat was spared (Figures 3 and 4). Sections from the margins of the specimen were normal. Sixteen lymph nodes were examined and found to be free of metastases.

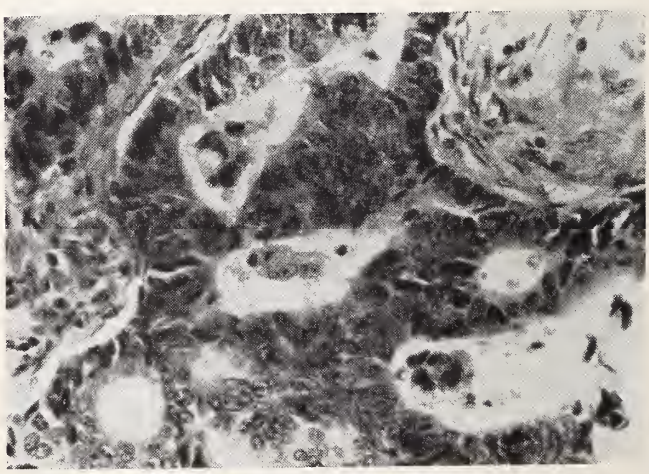
COMMENT

Symptoms and physical findings in carcinoma of the small bowel are often insidious and variable, the clinical picture being influenced by the presence or absence of obstruction, the location of the lesion, and the degree of bleeding.[5] Reports[3, 6] from Mayo Clinic divide the symptoms into three complexes—anemic, obstructive, and perforative and emphasize the complaint of abdominal pain and weight loss. Sixty-six per cent of the patients with jejunal lesions give one or more symptoms related to anemia, 70 per cent demonstrate some degree of partial or complete obstruction, and 14 per cent give symptoms referable to perforation. Prominent findings in the anemic group include fatigability, weakness, or dyspnea on exertion. This anemia is usually due to occult bleeding but may also result from a decreased absorptive capacity on the part of the small intestine. Obstruction is heralded by pain, vomiting, abdominal distention, and constipation. When the obstruction occurs in the upper jejunum, as it commonly does, vomiting is usually seen 2-3 hours after eating with copious loss of gastric, biliary, and pancreatic juices, resulting in dehydration.[5] The pain is usually severe and cramping in nature, being somewhat relieved by vomiting. The perforative syndrome becomes manifest when the neoplasm has perforated the intestinal wall. The pain then becomes localized and is referred via spinal somatic nerves.

The most common location for a jejunal carcinoma is in the proximal one-third, usually within 50 cm. of the ligament of Trietz.[8] The most common type is an annular constricting lesion producing varying degrees of obstruction, with secondary dilatation and hypertrophy proximal to the involved area. Other less common varieties include ulcerative and polypoid lesions.

Microscopically, these tumors are adenocarcinoma, some of the colloid or mucinous vari-





Figures 3 and 4. Infiltrating adenocarcinoma of jejunum involving the submucosa and muscularis.

ety, an abrupt transition being generally seen from normal mucosa to carcinoma. The early metastases involved adjacent mesenteric lymph nodes, with the nodal involvement usually being directly related to the grade of the lesion.[9] Sites of distant metastases include liver, lung, and long bones.

The diagnosis is extremely difficult, not only because one neglects to consider it, but also because of the paucity of localizing symptoms and signs.[10] Roentgenological examination of flat plate films of the abdomen will often reveal dilated loops of intestine proximal to the destruction. A more elaborate technique involves injecting a dilute barium mixture through a Miller-Abbott tube in an attempt to define a mucosal defect. Barsch[11] lists as diagnostic criteria an obliteration or alteration of the normal mucosal pattern, inflexibility of the portion involved, and compensatory dilatation proximal to the lesion.

Accepted treatment consists of wide resection with removal of accompanying mesentery and lymphatics. The lumen is re-established by end-to-end anastomosis. Palliative procedures for poor risk patients, or when extensive or distant metastases is present, include gastroenterostomy or enteroenterostomy.[12]

Colcock and Adamson[5] found in their series of 27 patients with carcinoma of the jejunum that the prognosis was guarded, even if the lesion was resectable. Forty-four per cent of their patients were dead within one year after surgery, and only 15 per cent survived five years.

The average postoperative survival in Pridgen series[3] on similar jejunal lesions was 30.8 months.

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Giant Calculus in a Diverticulum of the Male Anterior Urethra

A. BEKHRAD, M.D., and
D. A. CULP, M.D.
Iowa City

THIS IS A CASE REPORT of an unusually large calculus which occurred in a diverticulum of the anterior urethra of a non-paraplegic male patient. Calculi occurring under this circumstance are particularly rare.[1]

In review of the literature and discussion of this subject, Abeshouse[2] collected 130 acquired and 94 congenital urethral diverticula. Twenty-six of the acquired diverticula contained calculi, 16 of which were solitary. Thirty-one of the congenital type contained calculi and 14 were solitary. Mouat[3] reported a solitary calculus weighing 158 gm. Boeminghaus[4] reported a calculus weighing 136 gm. and measuring $6 \times 5 \times 4$ cm., Roith[5] recorded a stone the size of a billiard ball with a weight of 125 gm. Rumionlsev *et al.*[6] reported a case of urethral calculus weighing 500 gm. measuring $7 \times 8 \times 10$ cm. which was removed with uneventful recovery.

The calculus in this case dried at room temperature for four months weighed 110 gm. The

Dr. Culp is a professor in the Department of Urology at The U. of I. College of Medicine. Dr. Bekhrad is a professor of urology at the University of Isfahan in Iran. Dr. Bekhrad did advanced study at The U. of I.

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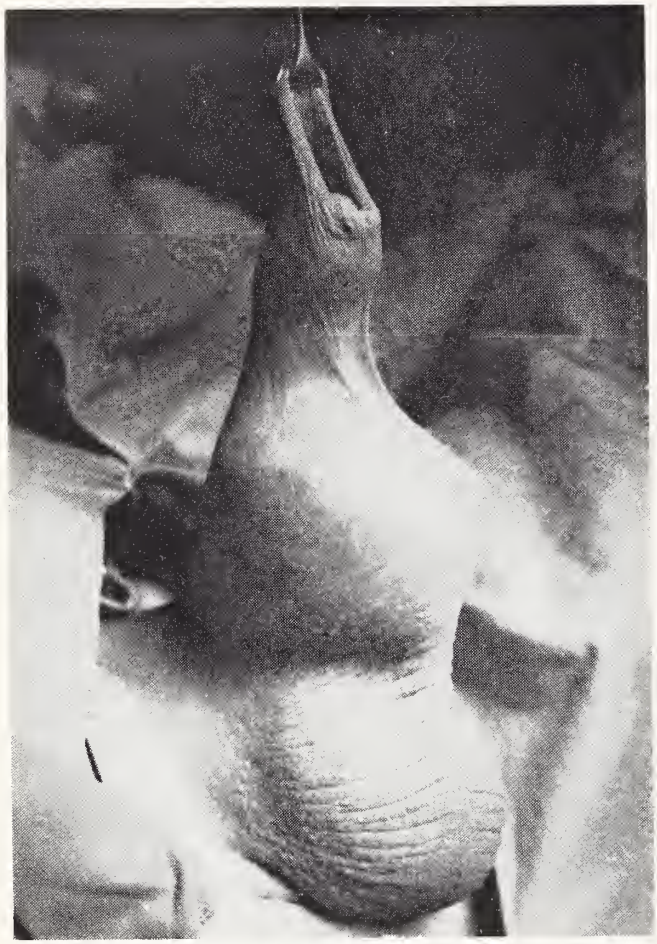


Figure 1. Preoperative Photograph.



Figure 2. Injecting urethrograms showing huge urethral diverticulum arising from anterior urethra filled with giant calculus.

largest and smallest circumferences were 17.7 cm. and 15.2 cm., respectively. The various diameters were 7.0, 5.5 and 4.5 cm.

CASE REPORT

W.L., a 64 year old feeble-minded white male, was committed to a State School for Mental Defectives in 1903 at age 8 years because of mental retardation and epileptic seizures. His mental retardation was of such severity that he was unable to communicate. In 1942 he was treated for frequency, dysuria, and hematuria and in 1950 for cellulitis of the penis and scrotum which resulted in abscess formation. A urethral calculus complicated by abscess and fistulae was noted in 1951. The patient was treated for urethral fistulae in 1952 and again in 1954. In early and late 1956 he was again treated for recurrent infections of the penis and scrotum. A medium orange-sized, very hard tumor in the scrotal region was noted in March 1959, and in April 1959 the patient underwent further investigation of this scrotal tumor. The patient was incontinent, but no other apparent difficulty with voiding was noted through the years.

The patient was first admitted to University Hospitals June 11, 1959. Physical examination demonstrated a feeble-minded, uncommunicative white male who appeared to be in a fair state of general health and periodically uttered unintelligible sounds. Positive physical findings were limited to the genitalia (see Figure 1, preop. photo). A small orange-sized, very hard mass occupied the ventral surface of the penis and extended to the penoscrotal junction. On each lateral aspect of this mass were three to four small fistulous openings that drained both pus and urine. The remainder of the penis, scrotum, and scrotal contents were not remarkable. Rectally, the prostate was minimally enlarged, smooth, mobile, firm, and benign in character.

The hemoglobin, white count, BUN and creatinine determinations were within normal limits. Attempts at obtaining a urine sample from the incontinent patient were unsatisfactory. Excretory urograms showed prompt, bilateral function from a normal appearing right kidney and from a left kidney exhibiting a normal collecting system with a 2 cm. radiopaque calculus in the renal pelvis. Multiple

small prostatic calculi were present along with a laminated calculus in the region of the penis. Serum calcium, phosphorus, total serum protein, and alkaline phosphatase levels were within normal limits. Injecting urethrograms (Figure 2) demonstrated a large laminated calculus in a diverticulum of the pendulous urethra. A large caliber stricture of the urethra distal to the diverticulum was apparent.

Eight days after admission the urethral diverticulum with its contained calculus, bilateral chronic periurethral abscesses and fistulous tracts, and a portion of the pendulous urethra were excised. The urethral defect thus created measured 2½ to 3 in. in length. This defect was covered with penile skin. Normal urethral mucosa was attached to the skin covering the urethral defect at its proximal and distal portions. Essentially, a first stage Johanson urethroplasty was performed, but the floor of the defect was covered with skin, rather than urethral mucosa. A #24 F sound passed readily through the remaining portions of the urethra and a #18 F Foley catheter was used to drain the bladder during the immediate postoperative phase. The wound itself was not drained.

Subsequent examination of the calculus (Figure 3) demonstrated it to measure 17.7 cm. and 15.2 cm. in its largest and smallest circumferences, and to have a diameter of 7.0, 5.5 and 4.5 cm. The calculus weighed 110 grams after dessication.

The urethral catheter was removed in one week and the patient voided incontinently as before. The postoperative course was essentially uncomplicated but it was necessary to use restraints in order to prevent auto-manipulation of the operative site. Two and one-half weeks after the operation the patient was discharged and apparently did well for one month when he was readmitted to the State School for Mental Defectives in a toxic condition. He expired the day after admission. The cause of death was attributed to an upper respiratory infection with acute fulminating encephalitis. An autopsy was not performed.

DISCUSSION

The etiology of this rather unusual calculus is somewhat obscured by the poor historical background. The patient was first noted to have findings referable to his urinary tract at the age of 47. The symptoms of bladder irritation and hematuria indicated the possible passage of a calculus originating in the left kidney with arrest in the urethra or trauma to the urethra during the passage of a calculus. Along with many other possibilities this episode may have represented a severe urethritis. Eight years later a periurethral abscess was noted followed in five months by the discovery of a urethral calculus and urethral fistulae. Over eight years elapsed before the patient was referred for urological investigation at the age of 64.



Figure 3. The giant calculus removed from a diverticulum of anterior urethra measured 7.0 × 5.5 × 4.5 cm. in diameter.

Our impression is that this calculus originated in an acquired diverticulum of the anterior urethra. The diverticulum developed secondary to intra-urethral rupture of a periurethral abscess or secondary to a calculus impacted in

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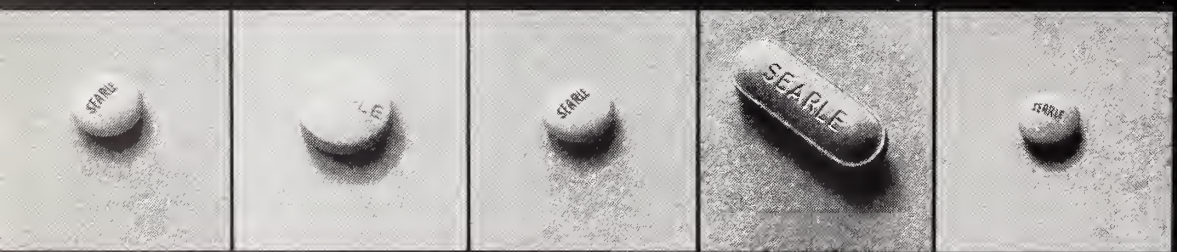
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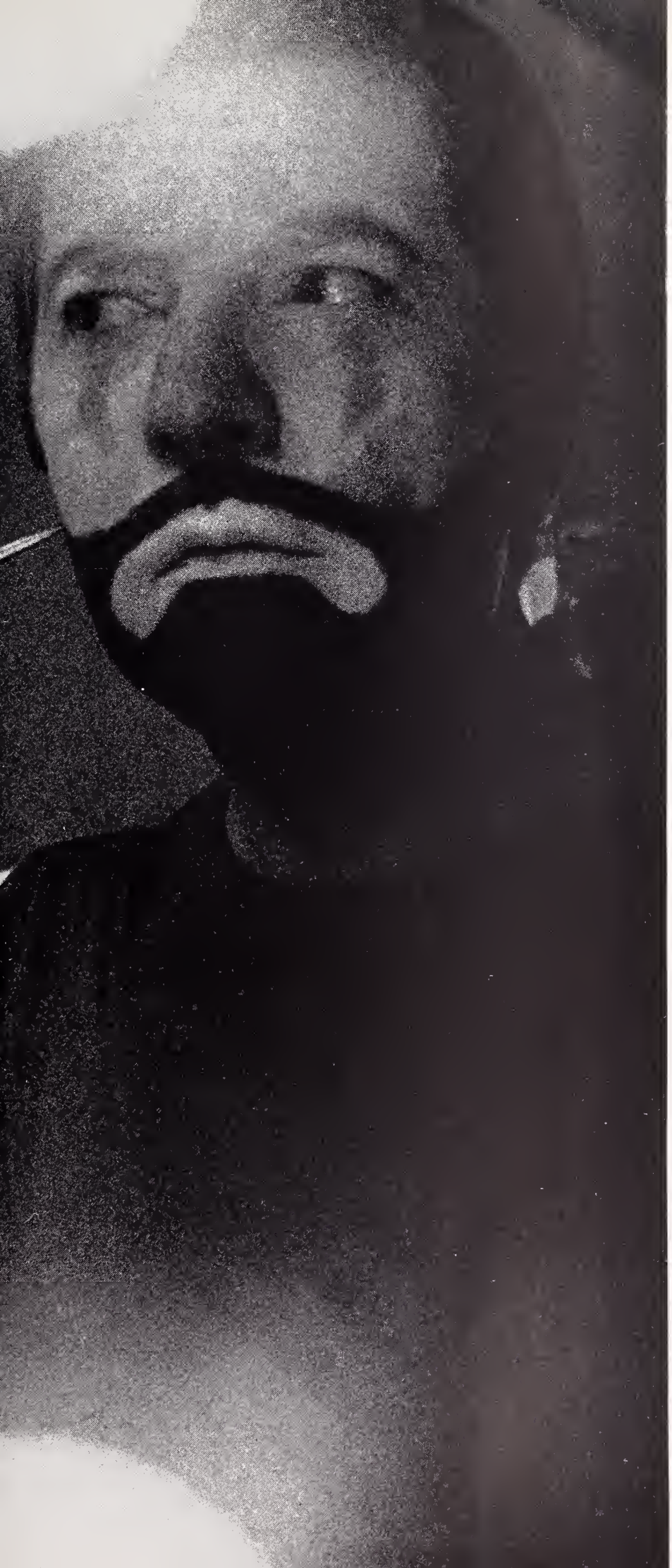
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the urethra with subsequent abscess and diverticulum formation. The enormous size of the calculus and the diverticulum are explained by the long period of time allowed for continued growth. Sections of the abscess cavity revealed a hyaline fibrous tissue sac lined by stratified squamous keratinizing epithelium with the surrounding fibrous and erectile tissue permeated by a dense, acute and chronic inflammatory cell infiltrate. These findings are consistent with, but not diagnostic of, an acquired diverticulum. A congenital diverticulum with secondary inflammatory changes could produce a similar pathologic picture. Analysis of the stone indicated it to be composed of calcium, magnesium ammonium phosphate, and calcium oxalate. These findings indicate a stone of infection.

We elected to excise completely the diseased portion of the urethra and modify the Johanson first stage urethroplasty by utilizing penile skin to cover the urethral defect. This plan was followed because of the impracticability of identifying the profoundly destroyed urethra. We had anticipated closing the defect at a future date by utilizing the Denis Browne principle for urethroplasty.

SUMMARY

A case of an unusually large calculus in a male anterior urethral diverticulum is presented. Comments are made regarding its etiology and treatment.

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Delayed Spontaneous Rupture of a Splenic Hemangioma

WILLIAM W. JONES, M.D., and
WILLIAM A. SYBERS, M.D.
Fort Dodge

THIRTY YEARS AGO in this JOURNAL, Nesler *et al.* published a case report of spontaneous rupture of a spleen with hemangioma.[13] The purpose of this article is to report a similar case and to remind a new generation of physicians about this unusual cause of acute abdominal pain.

CASE REPORT

This 59-year-old white male truck driver was in good health until four days prior to his hospital admission. Without any history of trauma he developed sudden severe left abdominal pain while unloading his truck. He vomited normal gastric contents twice. There was transient left shoulder pain. The pain became less severe so the patient drove 200 miles to his home. Although the pain persisted, he made two more trips in his truck for an amazing total of 600 miles before seeing his family physician two days after the initial onset of pain.

Examination by his family physician suggested a diagnosis of sigmoid diverticulitis. He was treated with antibiotics, liquid diet and bed rest.

The family history was noncontributory. At age 11 he experienced an uncomplicated appendectomy. Other than this he had always been in good health. There were no symptoms suggesting peptic ulcer disease. His bowel habits had always been normal, and he had noticed no tarry stools. He had not lost weight. There was no history of bleeding tendencies.

The day following his examination his con-

The authors are practitioners in Fort Dodge. Dr. Jones is a surgeon at the Kersten Clinic. Dr. Sybers is a pathologist at St. Joseph Mercy Hospital.

dition had deteriorated. He was weak, pale and tired. The abdominal pain was worse. He was again vomiting blood-free gastric contents.

The patient was hospitalized and surgical consultation was obtained. Examination showed a thin, elderly gentleman with abdominal pain. The blood pressure, pulse and respirations were normal. The temperature was 100.

The abdomen was moderately distended and only an occasional bowel sound was heard. There was muscle guarding on the left with maximum pain to palpation in the left lower quadrant. A well healed appendectomy scar was present. Rectal examination showed no evidence of rectal bleeding or masses. The lungs were clear and the heart was normal.

The admitting hematocrit was 26 and the white blood count was 11,000 with 80 per cent polymorphonuclear cells. The urinalysis was normal. The chest film revealed pulmonary emphysema. The flat plate of the abdomen showed adynamic ileus with suggestion of splenomegaly or a left soft tissue mass. There was no free air in the peritoneal cavity. A preoperative diagnosis of possible carcinoma of the descending colon with perforation and/or bleeding was made. Sigmoid diverticulitis, perforated gastric ulcer and dissecting abdominal aortic aneurysm were included in the differential diagnoses. The patient received two units of blood which increased the hematocrit to 29.

He was operated upon early the following morning. The abdomen was opened through a lower midline incision. A large amount of intraperitoneal blood was encountered. Rapid exploration found the great vessel to be intact, and the source of bleeding to be the spleen. The incision was extended up to the left 10th costal margin where the ruptured spleen was quickly mobilized and removed.

The patient received two units of blood during surgery and remained stable throughout the operation. He received one more unit of blood in the Intensive Care Unit for a total of five units during his hospitalization.

On the fifth postoperative day the patient became dyspneic. Auscultation revealed decreased breath sounds in the left lung base. A total of 1,100 cc. of pink serous fluid was removed from the left pleural space by thoracentesis. Following this the patient made a good recovery. He was re-admitted to the hospital two months later for a small bowel obstruction caused by peritoneal adhesions. An operation was performed to relieve the obstruction.

The spleen weighed 422 gm. The capsule was ruptured with a large hematoma protruding beyond the rupture.

On section the splenic parenchyma was moderately soft and contained numerous dilated thin-walled vessels varying in size from 1 to 22 mm. Microscopic section showed many large blood-filled spaces. Some were lined with endothelial cells whereas others consisted of a large dilated sinusoid. The diagnosis was cavernous hemangioma of the spleen with rupture.

DISCUSSION

Virchow was the first to describe splenic hemangioma in 1846.[10] The first successful splenectomy for splenic hemangioma was performed by Hodge in 1895.[11]

The incidence of this splenic tumor is about 0.1 per cent based on autopsy series.[10, 14, 15] Although rare, it is the most common benign tumor of the spleen.[14] Most are single and small (less than 1000 gm.), however some can become quite large (13,130 gm.).[8, 12] Sex incidence is 1.4 males to 1.0 females.[10]

A hemangioma is probably a malformation of congenital origin and represents a hamartoma "tumor-like malformation consisting of an abnormal mixture of normal organic elements."[8] This type of tumor grows slowly and can undergo hemorrhage, thrombosis, infarction, fibrosis and cystic formation. Most are of the cavernous type which are prone to cystic changes with intracystic hemorrhages.[10] They have been observed to increase in size during pregnancy.[5] Kellert's patient suffered from intermittent fever and was found to have an abscess within a hemangioma of the spleen.[17]

Malignant degeneration has been reported. Whitley and Winship reported one fatal case of angiosarcoma two years after removal of an apparent splenic hemangioma.[10] However, the majority are benign and the many reported cases of malignant hemangiomas probably represent multi-organ involvement of the same congenital vascular malformations.

Hypersplenism, although not common, has

been associated with large splenic hemangiomas.[10, 20, 23]

The most common complication of hemangioma is rupture.[8, 10] Spontaneous rupture can result from hemorrhage, infarction, or pressure necrosis. However, trauma plays a major role in the rupture of these fragile spleens. A history of trivial trauma can be elicited in most cases of splenic hemangioma rupture. Spontaneous rupture of a hemangioma of the liver has been reported and appears to be more lethal than splenic hemangioma rupture.[18]

Husni compiled from the literature 14 cases of splenic hemangioma rupture.[10] Eleven were thought to be spontaneous and three secondary to trauma. Four were a delayed type of rupture. Since Husni's paper, Inghan and Campbell have reported additional cases.[12, 5]

Inghan's case was a 29-year-old white female with a preoperative diagnosis of ruptured ectopic pregnancy with hemorrhage. She recovered after emergency laparotomy and splenectomy.[12] Campbell operated on a 20-year-old white pregnant female with a preoperative diagnosis of intraperitoneal hemorrhage. A Cesarean section for twins was performed. The cause of bleeding was found to be a ruptured spleen. A splenectomy was then performed with a successful outcome.[5] In both cases the spleen was found to contain a ruptured hemangioma.

With the addition of these 2 cases, plus the one presented in this report, a total of 14 cases of spontaneous rupture of the spleen with hemangioma have been reported. Of these, 11 have lived following splenectomy.

Without a history of trauma, the diagnosis of ruptured spleen is difficult. Most commonly a diagnosis of perforated gastric ulcer or acute appendicitis is made.[10, 12, 13]

Upper abdominal pain with radiation to the left shoulder (Kehr's sign) is helpful but often is only transient. Dullness to percussion over the left flank (Ballances' sign) may be present.[13] These signs in an anemic patient should make one suspicious of splenic rupture. X-rays are helpful. Free air under the diaphragm is lacking. Stomach fundus, spleen and descending colon displacement can be present. Separation of intestinal loops by blood is sometimes seen.[4] Abdominal parecentesis is helpful and should have been performed in this patient.

SUMMARY

Splenic hemangioma is found in about one patient in every 1,000 and can result in spontaneous rupture of the spleen. There have been 14 reported cases of spontaneous rupture of a splenic hemangioma, 11 of which survived splenectomy.

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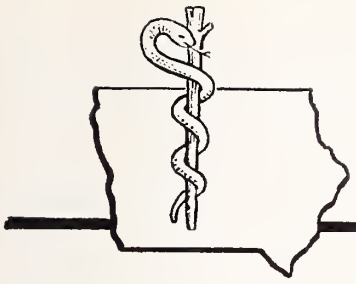
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Editorials

CARDIAC PACING

There have been numerous remarkable advances in medicine in recent years, probably none more dramatic than artificial pacing of the heart. Initially artificial pacing was used to correct bradycardia, but more recently pervenous or transvenous pacing has been used effectively in the management of patients with ectopic tachycardias. For various reasons this technique is now preferred to direct-current (d-c) cardioversion. A review* of the recent advances in the treatment of ectopic tachycardias by Barold and Linhart outlines the role of pacing in their management. The techniques vary according to the site of stimulation, the timing in the cardiac cycle, the rate and the duration of pacing.

According to the authors, cardiac pacing may be used both prophylactically and therapeutically in the management of ectopic tachycardias. Following open heart surgery or myocardial infarction pacing can be used to prevent the development of ectopic tachycardias by atrial or ventricular pacing for sustained periods at a rate faster than the spontaneous rate, but slower than the rate of the tachycardia being suppressed. Supraventricular tachycardias may be terminated, with the exception of atrial fibrillation, by pacing for brief periods, seconds or minutes, by a single stimulus or two serial stimuli in rapid succession, by repetitive stimulation at a rate slower than the existing tachycardia, or repetitive stimulation at a rate faster than the tachycardia.

In certain acute situations such as after cardiac surgery or myocardial infarction several methods of pacing may be employed. At open heart surgery the application of epicardial wires provides a simple technique for pacing. Under other circumstances epicardial pacing requires a thoracotomy. Pervenous or transvenous ventricular pacing has been found to be reliable and well established and it is the one most commonly employed. There have been many reports of its success in the treatment of ventricular disturbances of rate and rhythm from heart block to ventricular tachycardia to ventricular fibrillation. However, more recently, successful long-term pervenous right atrial and coronary sinus pacing having been reported in increasing numbers, particularly in the management of supraventricular arrhythmias.

It is emphasized that if A-V conduction is intact, atrial pacing is physiologically preferable to ventricular pacing because it permits tolerance of higher pacing rates, obviates ventricular irritability from the catheter itself and provides a hemodynamic benefit of the atrial booster pump which may help control the arrhythmia by improving the coronary circulation. One difficulty which is encountered in atrial pacing is the proper maintenance of the position of the catheter. This can be extremely difficult and if faulty can make the procedure unreliable and ineffectual.

Of special interest is the mechanism by which atrial pacing may slow the ventricular rate of supraventricular tachyarrhythmias which have been found resistant to all other forms of therapy. By pacing at an increased atrial rate it produces a functional A-V block which reduces the number of impulses transmitted to the ventricles, or it may induce a stable atrial fibrillation with a slower average

* Barold, S. S., and Linhart, J. W.: Recent advances in treatment of ectopic tachycardias by electrical pacing. AMER. J. CARDIOL., 25:698-705, 1970.

Editorials continued...

rate which is more readily controlled by digitalis.

The authors state that electrical pacing has added a new dimension to the management of ectopic tachycardias. To date clinical experience suggests that pacing, when indicated, offers certain advantages over standard d-c cardioversion for the termination of tachycardias. They list the following chief advantages:

1. *General anesthesia is not required.*
2. *There is no discomfort to the patient.*
3. *There is no postconversion ventricular arrhythmia, particularly in well digitalized patients.*
4. *Withdrawal of digitalis before conversion does not appear to be necessary.*
5. *Pacing may abolish arrhythmias caused by digitalis toxicity, a condition in which d-c cardioversion is usually unsuccessful and is dangerous.*
6. *Pacing may be brought about quickly, simply and repeatedly by leaving the pacing catheter in place.*
7. *The induction of sustained atrial fibrillation when sinus rhythm cannot be restored may be beneficial in certain situations.*

Certain disadvantages of pervenous pacing are enumerated:

1. *Fluoroscopy may not be readily available, however the catheter can be passed blindly to the right atrium with the help of the ECG.*
2. *Precipitation of ventricular irritability may result if the electrode becomes displaced from the atrium to the ventricle.*
3. *There is a small risk of producing ventricular arrhythmia by the delivery of a stimulus in the vulnerable period when competitive ventricular pacing is used.*

The authors admonish that pacing should be performed only when appropriate resuscitation facilities, including a d-c cardioconverter, are available, and after proper attention to the grounding of equipment to avoid accidental entry of current into the heart.

Obviously, pervenous pacing is a tremendous addition to the armamentaria of the cardiologist, but it has no place in the hands of an amateur. The new techniques should be a great interest to physicians confronted with patients presenting problems of cardiac arrhythmias.

DIGITALIS THERAPY

A recent article* entitled, "New Concepts of Digitalis," by Dr. Charles C. Wycoff, published in CALIFORNIA MEDICINE, December 1969, is deserving of the special attention of clinicians everywhere. The article consists of a review of two relatively new concepts concerning digitalis therapy which are a considerable departure from those of the past.

Doctor Wycoff points out that until the last decade or two digitalis was restricted for the most part to administration designed to slow the pulse during atrial fibrillation or flutter and to help the heart in frank failure. Another almost universal concept was that unless a "full digitalizing dose" was given, the drug was ineffective. Since 1950 laboratory and clinical studies have extended the indications for use of digitalis. The author in his review presents data to substantiate 1) there is a direct relationship between the dosage of digitalis and the contractile force of the heart, and 2) the drug is of benefit to the patients with cardiovascular disease even though the heart is not in frank failure.

The older concept was that "a digitalizing dose," calculated upon the basis of the patient's weight, had to be given before there was any beneficial effect. This idea resulted from the observation that large doses were necessary to slow the pulse rate in patients with auricular fibrillation and flutter. Usually it was the practice to give the drug in sufficient quantity to produce the desired therapeutic effect or to the point of toxicity and then lower the dosage to a point just short of the toxic level.

In 1950 an instrument, the strain guage, was developed, which when sutured to the ventricle

* Wycoff, C. C.: New concepts of digitalis. CALIF. MED. 111:423-432, 1969.

of the heart, measured the force of the myocardial contraction. Laboratory studies revealed that when the strain gauge was sutured to the right ventricle of dogs it showed that there was a direct relationship between the dose of the cardioactive drug tested and an increase in the contractile force of the heart. Further studies confirmed this observation and it was deduced from these that one of the physiological effects of the administration of digitalis was an increase in the contractile force of the ventricle and that it is dose dependent, i.e., a small dose produces a small increase in the contractile force and a large dose results in a large increase in contractile force. Thus, it was determined that the drug increases the contractile force of the heart whether it is normal, abnormal but not in failure, or in frank failure. The increased contractile force was shown to be beneficial not only in cardiac failure and arrhythmias but also in the heart subjected to chronic stress and in hearts with poor functional reserve.

The various studies lead to the belief that the administration of digitalis in certain patients without cardiac failure was helpful in certain situations. It was found that the prophylactic use of the drug may protect the myocardium in patients facing the depressing effects of anesthesia and operation. It has also been found helpful in hypotension resulting from trauma, shock, hemorrhage, and in serious infections such as pneumonia. Another clinical application is in chronic hypertension in which digitalis, by increasing the contractile force of the heart, reduces the development of hypertrophy and the hazard of failure. The drug has been found helpful following a myocardial infarction, in coronary insufficiency, and even in angina pectoris. Apparently the increased contractile force produced by digitalis results in better perfusion of the ischemic heart as well as the one damaged by a myocardial infarct.

The author emphasizes that the dose of digitalis must be individualized for each patient. Toxicity from the drug is entirely too common, and it is well recognized that it can produce arrhythmias which can be lethal to the patient in heart failure, particularly when the serum potassium level is low. The "digitalizing dose" has been assessed as 60 per cent of the toxic dose, and this is the amount which has been considered necessary in patients with congestive failure.

The recognition that even small doses of digitalis have a positive inotropic effect on the heart, resulting in an increase in contractile force, makes it possible to procure a beneficial effect from a much lower dose than that which was considered necessary in the past. In the event a maximum effect is desired the dose can be raised slowly over a period of several days, until there is evidence of toxicity, and then a slightly lower dose is continued.

As pointed out by the author, the early symptoms of digitalis toxicity are nausea, vomiting, yellow vision and scotomata, however rhythm disturbances may be the initial evidence of toxemia. The pulse should be checked for ectopic beats, bigeminy and runs of tachycardia. The ECG may show prolongation of the PR interval or a frank A-V dissociation.

The author calls attention to reports that "a full digitalizing dose" may become a toxic dose if a patient goes into failure. Other factors which make the heart more sensitive to the drug are a low level of serum potassium, a high level of serum calcium, hypoxia, oliguria, acute myocardial infarction and an individual variation.

In his conclusion Dr. Wycoff reiterates that the idea a "full digitalizing dose" must be given to produce a beneficial effect on the heart is postulated on the belief that the only effect of digitalis is the slowing of the rate of the heart in failure and the correction of certain arrhythmias. The studies in the last two decades have demonstrated that the increase in contractile force is the primary beneficial effect of digitalis. The administration of smaller doses than those required to slow the heart in atrial fibrillation are effective in improving the function of the heart.


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Editorials continued...

IMPRESSED BY AMERICAN YOUTH

A friend, recently returned from a European trip, told of an experience which reaffirmed her faith in American youth and created for her a feeling of great optimism for the future of our country. While traveling with a tour group, she had an opportunity to observe 150 high school students engaged in a summer educational program on the continent. The two groups intermingled both aboard ship and while exploring strange lands and studying ancient art and architecture and archeologic treasure.

The adult group was greatly impressed by the students on tour, impressed by their appearance and attire, by their deportment, by their interest and zeal, by their knowledge of history and art and ancient culture. They were particularly pleased by their many courtesies to the adult group.

With so much adverse publicity in the press and transmitted through the ether, it is good to hear such a complimentary assessment of a group of our young people. This particular group were superb ambassadors and their demeanor and conduct could not fail to make a favorable impression upon citizens wherever they traveled.

Would that our communications media give greater emphasis to what is good in this land of ours and of our people rather than to give so much space and time to what is wrong with our country and to the sins of society. For a change it would be pleasing for them to accentuate the positive. We are fortunate citizens to be living in these United States of America. It isn't Utopia but can you name a better place?

DIAGNOSING VENOUS THROMBOSIS

An article* in the April 18 issue of the BRITISH MEDICAL JOURNAL on the accuracy of diagnosis of postoperative venous thrombosis should be of unusual interest to the many physicians who are confronted with this common problem. The frequency and the high mortality of pulmonary embolism complicating venous thrombosis is a constant concern to surgeons, and particularly to gynecologists and orthopedists.

The authors, a group from the University of Aberdeen and the Royal Infirmary, Aberdeen, present a study to evaluate the accuracy of the clinical diagnosis of venous thrombosis in a group of 111 surgical patients. The patients were considered to be at high risk in terms of developing postoperative thrombophlebitis. They were (1) obese gynecologic patients over 45 years of age undergoing hysterectomy or repair of the pelvic floor, (2) general surgical patients over 40 years of age undergoing major abdominal surgery, and (3) elderly patients having internal fixation of fractures of the femoral neck.

Clinical evaluation of the patients was made by 1 of 2 independent observers on at least 6 of the first 10 postoperative days. The clinical diagnosis of venous thrombosis was left to the discretion of the clinician after repeated examination and his findings were recorded.

The accuracy of clinical diagnosis in the group of patients was checked by a special technique employing radioactive iodine. The test was predicated on the concept that the incorporation of radioactive iodine-tagged fibrinogen into the matrix of the evolving thrombus permits the resulting area of increased radio-

* Lambie, J. M., Mahaffy, R. G., Barber, D. C., Karmody, A. M., Scott, M. M., and Matheson, N. A.: Diagnostic accuracy in venous thrombosis. BRIT. MED. J., 57:142-143, 1970.

activity to be detected by scintillation scanning. Immediately after the operation ^{125}I-fibrinogen was injected intravenously, and the patient's legs were scanned daily for the first 8 to 10 days following the operation.

Of the 111 patients a positive clinical diagnosis of deep vein thrombosis was made in 25. Scintillation scanning confirmed the diagnosis in 18, thus the clinical diagnosis was falsely positive in 7. A positive diagnosis of venous thrombosis was made by scanning in 49 of the 111 patients (44 per cent); in 12 of the group, thrombosis was detected in both legs; thus in a total of 61 legs with proven thrombosis a clinical diagnosis was made in only 19 of them. Phlebography confirmed the accuracy of the radioactive iodine technique. Especially significant, according to the authors, was the finding that of the 61 thrombi, 31 were detected on the first postoperative day, 8 on the second day, and thereafter with decreasing frequency.

In a discussion of the results of the study it is stated that "even close and repeated clinical evaluation is highly unreliable, and little store should be set by it." The authors suggest it is wiser for physicians to be conscious of the large number of patients who have venous thrombosis of the leg and thigh despite the apparent normality of the legs. They also say that the true incidence of venous thrombosis in patients such as those studied is probably even higher, since about half of the group was receiving prophylactic anticoagulant therapy.

The authors assert that the prevention of pulmonary embolism depends largely on early clinical diagnosis and the treatment of deep vein thrombosis. Since the clinical recognition is so undependable it is clear that most patients with leg and thigh venous thrombosis and at risk of pulmonary embolism are untreated. Even when the condition is recognized, the treatment of established venous thrombosis is at present disappointing. However, the authors do acknowledge that the widespread adoption of the scintillation scanning technique is impractical because it is time consuming and sophisticated.

The results of the investigation strongly support the argument that a reduction in the incidence of pulmonary embolism after operation must depend upon vigorous and widespread use of effective prophylaxis against venous thrombosis, particularly in high risk patients. The frequency with which thigh and leg venous thrombosis is demonstrated soon after operation suggests that prophylactic measures must be initiated while the operation is in progress. The techniques utilized by the Aberdeen group should be particularly useful in the objective evaluation of any prophylactic measures attempted.

NEW APPROACH TO VENOUS THROMBOSIS

As a consequence of the findings and conclusions by the Aberdeen physicians, as summarized in the preceding editorial concerning the need for an effective method of prophylaxis of postoperative venous thrombosis, the group tells in the same issue of the BRITISH MEDICAL JOURNAL of their experience with a new approach to the problem.*

The authors point out the prevention of venous thrombosis is now being looked at afresh, that the use of radioactive iodine and scintillation scanning has demonstrated "that the time honored dependence on leg exercises and elastic stockings is about worthless." The present interest in the prevention of intravascular thrombosis is directed to drugs which affect platelet behavior and which hopefully might suppress the thrombotic process at its inception.

Several studies have demonstrated that infusion of low molecular weight dextran (dextran 70) depresses platelet adhesiveness in both normal individuals and postoperative patients in whom platelet adhesiveness was increased. It has also been shown that dextran 70 had a marked suppressive effect on platelet activity

* Lambie, J. M., Barber, D. C., Dhall, D. P., and Matheson, N. A.: Dextran 70 in prophylaxis of postoperative venous thrombosis. BRIT. MED. J., 57:144-145, 1970.

Editorials continued...

at the site of endothelial damage. Two earlier studies demonstrated that dextran 70 provided significant protection against venous thrombosis in patients with fractures of the femoral neck.

Anticoagulants have been widely accepted as effective in the prophylaxis of venous thrombosis, however they present problems in controlling the dosage and there is always the hazard of hemorrhage from their use. The authors undertook the reported trial to compare the efficacy of dextran 70 with that of oral warfarin in the prevention of postoperative venous thrombosis.

The study group consisted of 80 women, all of whom underwent major gynecologic surgery and were considered to be at high risk of developing venous thrombosis. Patients were assigned to prophylactic treatment groups by random selection. Forty patients were given oral warfarin following a regimen used with gynecologic patients in Aberdeen over the last 10 years. The drug was started 36 hours after the operation. Forty patients were given dextran 70, 7 mg/kg daily on each of the first three postoperative days. Immediately after the operation an infusion of radioactive iodine-tagged fibrinogen was given intravenously, and the patients' legs were scanned daily for 8 to 10 days.

In the group of 40 patients who were given warfarin 12 patients developed deep vein thrombosis. Six of these were classified as major; 2 had bilateral thrombosis below the knee and 1 had developed pulmonary embolism; 3 had thrombosis of thigh veins, and 1 had extensive thrombosis below the knee. The other 6 had minor thrombi in veins of the calf.

In contrast to the group who were given anticoagulants, no major thromboses occurred in the patients given dextran 70. Only 4 patients developed deep vein thrombosis and in each of these it was a single minor thrombus confined to calf veins.

From the results of their study the authors conclude that dextran 70 given during the operation and for 3 days afterwards protects high risk patients against thigh and leg venous thrombosis, and the results are better than warfarin started 36 hours after the operation. Of special significance is the fact that in 10 of the 16 patients who developed deep vein thrombosis, it was present on the first postoperative day (in 7 of the 12 in the warfarin group). Thus, they conclude that if anticoagulant therapy is to be effective prophylactically, it must be established at the time of operation. This means it must be started 36 hours before the operation, which surgeons are loathe to do because of the hazard of hemorrhage.

It is pointed out that the beneficial effects of dextran 70 may not depend entirely upon suppression of platelet activity. Infusion of this product expands plasma volume, which results in increased cardiac output and increased venous blood flow. Dextran has also been found to coat the vascular endothelium which may be a factor in its efficacy in the prevention of thrombus formation.

The authors conclude with the statement that dextran 70 has been shown to be a simple and safe prophylactic agent against postoperative venous thrombosis in the legs and thighs. It appears to be preferable to anticoagulants, however a carefully controlled trial of these agents begun before operation is desirable. Such a controlled trial is currently in progress by the Aberdeen group.

Low molecular weight dextran is now available in this country and it is being used in some medical centers in the manner described by the Aberdeen group. The dextran employed in the British study was dextran 70. In this country the dextran used is usually dextran 40, which is about one-half of the molecular weight used in the British study.

THE JOURNAL *Book Shelf*



BOOK REVIEWS

Gas Chromatography in Biology and Medicine, Ciba Foundation Symposium, ed. by *Ruth Porter*. (J & A. Churchill Ltd., London, 1969).

This book contains the proceedings of a symposium held for persons working in the field of gas chromatography. Papers presented and the ensuing discussions are included.

The book is divided into three sections. The first and third are devoted to instrumentation, especially columns and detectors; the second is devoted to applications of gas chromatography to the detection of components of biological specimens. Examples are blood gases, anaesthetics and toxic compounds.

The purpose of the symposium was ". . . to promote the exchange of ideas about gas chromatography and its applications" by experts working in the field. As such, the ideas presented here are of great interest to one doing research on or with gas chromatography. Many interesting insights for further development can be gained from the reading of this book.

However, this work was not intended to be and is not either an introduction to gas chromatography or a comprehensive treatise on it.

A person wanting stimulation for further work on gas chromatography should find this a very valuable book; one wishing to set up an instrument in a laboratory for routine determinations of components of biological specimens probably would not.—*Norman B. Coffman,* Ph.D.

Diseases of Bone and Joint, by *Louis Lichtenstein,* M.D. (St. Louis, C. V. Mosby Company, 1970, $17.50).

Louis Lichtenstein is well known among pathologists and orthopaedic surgeons. His books on bone tumors are classics in their field. They contain concise, accurate, and often original observations on one of the most difficult fields in pathology.

This book affords the author an opportunity to express himself on nonneoplastic bone lesions. Some of the book is based on original work by Dr. Lichtenstein on such subjects as aneurysmal bone cyst, fibrous dysplasia, eosinophilic granuloma of bone, and pigmented vilonodular synovitis. Most of this has been published elsewhere, but this book collects these papers in one handy reference work.

The principal weakness in the book lies in the fact that it provides a rather superficial look at skeletal changes in endocrine disorders, osteoporosis, skeletal changes in renal diseases and skeletal anomalies when compared with other available works. In spite of these weaknesses, the book is a valuable companion to bone tumors by Lichtenstein.—*John H. Kelley,* M.D.

Modern Treatment, Vol 7, No. 2, Treatment of Pyelonephritis, ed. by *John H. Moyer,* M.D. and *Charles D. Swartz,* M.D., Diuretics in the Management of Fluid Retention, ed. by *Henry O. Heinemann,* M.D. (New York, Harper & Row, 1970, $20 per year).

The section on pyelonephritis may be of help to the practicing physician who has no concept of the disease or the importance of the disease in the etiology of hypertension and/or renal failure. Several points may be frustrating to many physicians in practice, however. The use of quantitative urine cultures is stressed in the diagnosis and follow-up of pyelonephritis. Quantitative urine cultures are not available in most community hospitals.

The paper by Dr. Heinemann does offer some practical, although less desirable alternatives to quantitative urine cultures.

The section on use of diuretics, although somewhat repetitious, does offer guidance in the use of diuretics in specific circumstances.—*William C. Rosenfeld,* M.D.

Essentials of Gastroenterology, by *J. Ned Smith, Jr.,* M.D., and *Kyo R. Lee,* M.D. (St. Louis, C. V. Mosby Company, 1969. $14.75).

The purpose of this book, as mentioned in the preface, is "to present in a brief form, the important aspects of the etiology, diagnosis, and treatment of various gastrointestinal disorders. The material is intended primarily for medical students who are acquiring their initial knowledge of gastroenterology. The information in the bibliography may also be of interest to graduate physicians. No attempt was made to include the entire gastrointestinal field."

It may be of parenthetical interest to Iowa readers that Dr. J. Ned Smith, Jr., had his first introduction to gastroenterology at the University of Iowa. The small book discusses many of the most common gastroenterological diseases and a few of the uncommon diseases. The book is small (intentionally so) and discusses such subjects as hemorrhage secondary to peptic ulcer in two-and-a-half pages. It is also amply supplied with x-ray films, which are typical of vari-

ous conditions, and photomicrographs of various pathological processes.

The book introduces the students and the doctor, having a casual interest in gastroenterologic conditions, to the whole field of gastroenterology. Special points, diagnosis, clinical course and treatment are mentioned briefly so that it is a very handy reference for one who wishes to learn about a certain particular subject quickly. It would be, therefore, of excellent use to the internist and the general practitioner, in addition to the student, as an office reference book. The author does not hesititate to mention his own personal preferences in treatment, instead of entering into a lengthy discussion about the pros and cons of all types of treatments. Such small texts are indeed unusual in the age of burgeoning knowledge, but they are very important for a doctor who wishes to have general information about gastroenterological conditions at his fingertips.—*Daniel A. Glomset,* M.D.

CURRENT DIAGNOSIS AND TREATMENT, Ninth Edition, by *Henry Brainerd,* M.D., *Marcus A. Krupp,* M.D., *Milton J. Chatton,* M.D., *Sheldon Margen,* M.D., and associate authors. (Los Altos, California, Lange Medical Publications, 1970, $9.50).

This book is a very useful "P.D.R." of currently accepted techniques for diagnosis and treatment of internal medical disorders mainly. It encompasses symptoms, systems and specific diseases in a time-saving, yet thorough summary or outline form. Physicians who treat medical problems should find it valuable and likely to be used often in these days of being so busy that quick, accurate information on our daily problems is most welcome.—*L. W. Swanson,* M.D.

BOOKS RECEIVED

SYNOPSIS OF EAR, NOSE AND THROAT DISEASES, THIRD EDITION, by *Robert E. Ryan,* M.D., B.S., M.S., F.A.C.S., *Joseph H. Ogura,* M.D., F.A.C.S., *Hugh F. Biller,* M.D., and *Lindsay L. Pratt,* M.D. (St. Louis, C. V. Mosby Company, 1970, $10.75).

MODERN TREATMENT, Vol. 7, No. 1, TREATMENT OF CARDIAC ARRHYTHMIAS, ed. by *Noble O. Fowler,* M.D. (New York, Harper & Row, 1970, $20.00 per year).

MEDICINE AND STAMPS ed. by *R. A. Kyle,* M.D., and *M. A. Shampo,* Ph.D. (Chicago, American Medical Association, 1970, $1.00).

CURRENT PROCEDURAL TERMINOLOGY ed. by *Burgess L. Gordon,* M.D., *William R. Barclay,* M.D., and *Charlotte Fanta,* B.S. (Chicago, American Medical Association, 1970, $2.00).

HOMEOSTATIC REGULATORS, Ciba Foundation Symposium held jointly with Wellcome Trust, ed. by *G. E. W. Wolstenholme* and *Julie Knight.* (J. & A. Churchill Ltd., London, 1969).

FOETAL AUTONOMY, Ciba Foundation Symposium, ed. by *G. E. W. Wolstenholme* and *Maeve* O'Connor. (J. & A. Churchill Ltd., London, 1969).

MUTATION AS CELLULAR PROCESS, Ciba Foundation Symposium, ed. by G. *E. W. Wolstenholme* and *Maeve* O'Connor. (J. & A. Churchill Ltd., London, 1969).

HANDBOOK OF LEGAL MEDICINE, 3rd ed., by *Alan R. Moritz,* M.D., and *R. Crawford Morris,* LL.B. (St. Louis, C. V. Mosby Company, 1970).

INSTRUCTIONAL COURSE LECTURES, Vol. XIX, by American Academy of Orthopaedic Surgeons. (St. Louis, C. V. Mosby Company, 1970, $19.50).

WINE AND THE DIGESTIVE SYSTEM by *Salvatore Pablo Lucia,* M.D. (San Francisco, Fortune House, 1970, $3.50).

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Influenza Vaccine

Influenza, a common respiratory illness occurring in the United States each year, appears periodically in epidemic form. Epidemic periodicity is thought to result from antigenic variations in the prevalent influenza viruses and from the proportion of susceptible and immune individuals in the population. The probability of an epidemic in any year depends to a considerable degree upon the extent of recent influenza in the community and the extent of antigenic change in the prevalent influenza viruses.

Inactivated influenza vaccines* have been variably effective and have offered rather brief periods of protection. Control of epidemic influenza in the general population is therefore not possible through routine vaccination.

Still, influenza vaccines are our best available preventives of influenza. Their SELECTIVE use can be readily justified for chronically ill patients of all ages and for older persons in the population. Individuals in both groups are characteristically at greatest risk of serious complications or death from influenza or its complications.

Previous recommendations for using influenza vaccine have incorporated forecasts of expected influenza activity in the coming year. These forecasts may have led to the misunderstanding that vaccines should be employed only in years when epidemics are predicted. It should be emphasized that some influenza A or B cases occur in the United States each year, although their frequency and geographic extent may vary widely. Annual vaccination of all individuals for whom influenza would be a significant hazard is recommended regardless of the expected occurrence of influenza in any area.

INFLUENZA VIRUS VACCINES

The Division of Biologics Standards, National Institutes of Health, regularly reviews influenza vaccine formulation and, when indicated, recommends revisions to include contemporary antigens. Strains of influenza A examined in the United States and abroad in 1969-70 did not differ significantly from the Hong Kong strain, A2/Aichi/2/68. For 1970-71, the composition of the vaccine will remain the same as the bivalent vaccine recommended for 1969-70. The adult dose of inactivated influenza vaccine will contain 400 chick cell agglutinating (CCA) units of type A2 antigen (A2/Aichi/2/68) and 300 CCA units of type B antigen (B/Mass/3/66).

Highly purified vaccines will be available from most manufacturers. These highly purified vaccines are equivalent in potency to earlier vaccines, but contain less nonviral protein and are the recommended products where available.

RECOMMENDATIONS

Annual vaccination is recommended for persons of all ages who have chronic debilitating conditions: 1) congenital and rheumatic heart disease, especially mitral stenosis; 2) cardiovascular disorders such as arteriosclerotic and hypertensive heart disease, particularly with evidence of cardiac insufficiency; 3) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, cystic fibrosis, bronchietasis, emphysema, and advanced tuberculosis; or 4) diabetes mellitus and other chronic metabolic disorders.

Candidates for influenza vaccine who have had severe local or systemic reactions to the vaccine in the past may experience less discomfort if the highly purified vaccine is used.

Although the indications for vaccination of all older persons are less clear, older persons who may have incipient or potential chronic disease, particularly those affecting cardiovascular and bronchopulmonary systems, should also be considered candidates for annual vaccination.

Immunization of persons involved in providing essential community services may also be considered. However, before embarking upon such a program, physicians responsible for such groups must take into account a number of factors including: the difficulties inherent in prediction of influenza epidemics, the variability of vaccine effectiveness, the incidence of side reactions, the cost of the programs, the availability of the vaccine, and the diversion of existing vaccine supplies from those with chronic debilitating conditions who are at high risk.

VACCINATION SCHEDULE

The primary series consists of 2 doses administered subcutaneously, preferably 6 to 8 weeks

* The official name of the currently available product is Influenza Virus Vaccine, Bivalent.

apart. (Dose volume for adults and a detailed schedule for children is specified in the manufacturers' labeling.) Persons who had 1 or more doses of the vaccine containing Hong Kong strain antigen in the 1968-69 or the 1969-70 seasons require only a single subcutaneous booster dose of bivalent vaccine. All others should receive a primary series. Vaccination should be scheduled for completion by mid-November.

PRECAUTIONS

Influenza vaccine is prepared from viruses grown in embryonated eggs and ordinarily should not be administered to persons hypersensitive to ingested or injected egg protein.

Tuberculosis in Summary

TUBERCULOSIS INFECTION is from airborne bacilli; it is not a contact infection. Bacilli carried on droplet nuclei (5 micra or .005 mm. in size) can reach the alveoli and establish infection; those borne on larger droplets are extruded by ciliary action.

SKIN TESTING should be done using 5TU of PPD tuberculin injected intradermally (Mantoux). Reactions should be measured and recorded in millimeters of induration. Less than 5 mm. of induration is a negative reaction, 5 to 9 doubtful (may be tuberculosis or may be atypical infection), 10 mm. and above positive. In the multiple puncture technique (such as Heaf or tine) the dose of tuberculin carried into the skin cannot be measured and is often more than 5TU. A positive reaction with Heaf or tine requires re-testing with intradermal 5 TU of PPD tuberculin.

MOST DISEASE, probably about 80 per cent, is of endogenous origin—i.e., it is not original infection but reactivation of previous infection. Reactivation occurs most frequently from recent infections, decreases in frequency as the time of infection becomes more remote.

CHEMOPROPHYLAXIS with isoniazid (INH) 300 mgm. in a single daily dose for one year is a proved method of reducing the number of later cases of tuberculosis. If it is started early after conversion of skin test, reversion to negative frequently occurs. The National Communicable Disease Center's recommendations are:

PRIORITY CANDIDATES FOR PREVENTIVE TREATMENT

"While all infected persons may benefit from preventive treatment, priority effort should be made to identify and treat individuals in the following groups:

1. Positive tuberculin reactors with "pulmonary fibrosis" or old fibrotic lesions presumably tuberculous in origin, former tuberculosis patients who have never had specific chemotherapy or who have had inadequate drug therapy (e.g., treatment for less than 18 months, no isoniazid, etc.). At particularly high risk are persons with pulmonary lesions of unknown etiology, compatible with tuberculosis, in which active disease has been excluded.

2. Members of the household of a newly diagnosed case of tuberculosis, regardless of tuberculin status. Preventive treatment for these household contacts should continue for a full year, even when exposure to the infectious case has ended and tuberculin tests remain negative. Preventive treatment of negative reactors should also be given other persons who have had close, extended exposure comparable to that of a person living in the same household with an active case.

3. Persons known to have recently become infected, i.e., converted from negative to positive tuberculin reaction.

4. Children who are reactors through the age of adolescence.

5. School personnel and other adult reactors closely associated with children.

6. Tuberculin reactors in certain clinical situations known to lessen their resistance to disease: prolonged corticosteroid treatment, gastrectomy, leukemia, silicosis, Hodgkin's disease, pneumoconiosis, severe or poorly controlled diabetes, pregnancy, and children with measles or whooping cough. In the case of pregnant women, treatment should be started in the last trimester."

ISONIAZID FOR PREVENTIVE TREATMENT

"A single drug, isoniazid, is generally used for treatment of infection in a dosage of 300 mg/day for adults and 10 mg/kg body weight for children, not to exceed 300 mg/day, and to be administered daily for a period of 12 months."

TREATMENT of tuberculosis aims to render secretions free of tubercle bacilli, obtain healing and regression of lesions, and restore normal function. To be adequate, chemotherapy must be intensive at the onset and must be prolonged. Individual problems and idiosyncrasies must be taken into consideration in prescribing medications. Today it is usual to administer three drugs at the outset—usually INH, PAS, and streptomycin. Ethambutol (Myambutol®, Lederle) is an excellent drug which will probably soon be used as an original medication. Prizinamide, ethionamide, cycloserine, kanamycin, viomycin are useful drugs, second-line because of toxicities which require constant monitoring for side effects. Multiple drugs should be given for at least one year after disease becomes inactive. INH alone is often continued after that.

BACTERIOLOGY is the reliable guide to progress. Frequent secretion studies with susceptibility determinations on every positive culture are required for adequate and proper treatment. Knowledge of emergence of resistance is necessary to assure that suitable medications are being given. The State Hygienic Laboratory is able to do susceptibility testing.

ACTIVITY of the disease is thoroughly described and explained in Chapter 6 of "Diagnostic Standards and Classification of Tuberculosis," pub-

lished by the National Tuberculosis and Respiratory Disease Association. When cultures have been negative for 3 months, disease is considered quiescent if noncavitary; when negative for 6 months inactive if noncavitary. In all situations diagnosis depends upon CULTURE, not smear.

TUBERCULOSIS caused 37 deaths in Iowa in 1969 and 128 new cases were reported.

Morbidity Report for Month of August 1970

Diseases	Aug. 1970	1970 to Date	1969 to Date	Most August Cases Reported From These Counties
Blastomycosis	1	1	0	Scott
Brucellosis	6	34	30	Dubuque
Chickenpox	4	4110	3428	Polk
Conjunctivitis	10*	231	265	Johnson
Encephalitis viral	2	2	8	Carroll, Cerro Gordo
German measles	9	2008	2219	Palo Alto
Gonorrhea	456	3541	2710	Scattered
Histoplasmosis	2	11	14	Allamakee, Polk
Impetigo	21	303	247	Polk
Infectious hepatitis	21	223	263	Polk, Scott
Infectious mononucleosis	11	366	385	Scott
Malaria, imported				
P. vivax	3*	15	9	Carroll, Linn, Polk
type undetermined	1*	2	0	Woodbury
Measles	32	1088	331	Buena Vista
Meningitis				
hemophilus	1*	1*	0	Dubuque
meningococcal	1	11	16	Worth
pneumococcal	1	1	4	Page
viral	2	3	2	Dubuque
type unspecified	4	11	15	Cerro Gordo, Des Moines
Meningo-encephalitis	1	5	5	Des Moines
Mumps	11	2290	3945	Black Hawk, Des Moines, Dubuque
Pneumonia	37	620	311	Scott
Rabies in Animals	6	71	64	Linn
Rheumatic fever	2	41	28	Black Hawk, Jackson
Salmonellosis				
S. bredeney	1	1	0	Dubuque
S. heidelberg	1	2	1	Black Hawk
S. infantis	1	4	1	Scott
S. java	1	1	2	Wapello
S. manhattan	3	3	1	Dubuque, Johnson
S. typhimurium	5	19	27	Fremont, Mahaska, Polk, Sac, Wapello
Shigellosis				
S. sonnei	4	47	23	Dubuque, Jackson, Jefferson, Webster
Streptococcal infect.	227	4591	2985	Johnson
Syphilis	30	357	479	Scattered
Tuberculosis, active	7	92	85	Scattered
Whooping cough	1	15	6	Des Moines

* Delayed

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Woman's Auxiliary News

Musing with Marion . . .

In August all roads lead to the Iowa State Fair. Were you there?

Everybody must have been sometime; there were such crowds. It's been a family ritual ever since I can remember. I went through phases when I was bored to pieces, but since I've been working a shift in the Hall of Health for the Iowa Medical Society I've looked forward to the Fair. It's a real pleasure to explain the exhibit, to select pamphlets, to answer questions, People are eager for information and enthusiastic about the material. Many children use it for school reports. The exhibits are good public relations for our husbands. (Incidentally, take along some handwork—it's a great means of establishing communication.)

Several tables held pamphlets on diabetes, foot problems, cancer and nursing careers. Illuminated exhibits were on the ear, diet and food. Different 30-minute films were shown each day. I saw those on the *AMA* and *The Cost of Hope* (Hospital Care). A Des Moines high school student ran the projector and helped to clean up pop and ice cream that was spilled on the tables or exhibits. Don Neumann from the IMS staff and his son, Tim, took over the afternoon shift the day I was there.

Other Auxiliary members there during the week were: Elaine Olsen and her daughter Maureen, Matilda Vorisek, Justine Foley, Bunny Wicks, Vi Elliott and Mrs. Hintz. To these and others who may not have had their names on badges, thanks for sharing this opportunity.

With summer activities and the Fall Board Meeting behind us, let's focus on the year's business. Give *Membership Priority Now!* Erlene Veverka sent out the cards early in September, so let's all pitch in to realize our goal of a member from every county in which there is an IMS member. Recruit for the IMS, if necessary, to get the job done.

There are no finer or more capable women than Auxiliary members, so I know that community health needs will be met when all of you get into gear. Again, best wishes for a happy, satisfying year; it will be a privilege to help you, if I can.

MARION PREWITT

AUXILIARY in ALASKA

In June, while Dr. and Mrs. Olin Elliott of Des Moines were traveling in Alaska, that state's Medical Auxiliary was holding its Annual Meeting. Our Recording Secretary is happy to share with us the cordiality extended to her at that time.

Mrs. Paul Isaak was hostess for lunch in Soldotna where she and Dr. Isaak live. The barbecued moose meat and all other food served, except the lettuce, were products of the peninsula. Mrs. Wendell Roller of Monmouth, Illinois, was also a guest and spoke of her work for the National Auxiliary as Health Careers Chairman.

The wife of the past president of the Alaska Medical Society, Mrs. Warren Jones of Anchorage entertained at the Harborview luncheon. Mrs. Elliott was seated between Mrs. Henry Akiyama of Juneau, the Alaska Auxiliary President, and the wife of the incoming president of the Juneau Area Medical Society.

The Reverend Paul McCleave of Chicago was the luncheon speaker. His remarks concerned his work as Director of the AMA Department of Medicine and Religion. He reported that kits on Medicine and Religion are now available to the Auxiliaries. He advised that the films *One Who Heals* (with film user's guide) and *A Storm—A Strife* were excellent for programs. He cautioned the ladies, however, to let their husbands have priority in their use. Finally, he urged Auxiliaries to invite the wives of clergymen to their meetings.

Mrs. Elliott also toured a Russian Orthodox Church with several members. This was located in Kenai.

* * *

The Alaskan village came to life for Dr. and Mrs. Elliott when they attended a banquet at the Kenai Catholic Church. They were seated next to Dr. Spencer and his wife Mary, who serves also

as a nurse in the small village of Sitka. Eight miles of road extend from each end of Kenai, making the ferry boat and the plane the only means of transportation beyond the eight mile limit.

The Elliotts flew with a bush pilot in his Cessna 185 into the country near Seldovia to fish for red salmon and trout. Five days were spent at the Land's End, located on the tip of Homer's Spit, which is known as the vacation land of Alaska. Both the Elliotts had excellent luck fishing for Dolly Varden in this area.

Upon their arrival in Anchorage, the Elliotts were exposed to an earthquake which measured over 5 points on the Richter scale. The disastrous quake in 1964 was 8 on the scale. Also, the day they left Kenai, 2,900 acres of timber were destroyed by fire. Because of the financial problems in Alaska, it was theorized that the fires were deliberately started to create work for local inhabitants.

Despite the majestic splendor that nature provides in Alaska and the warm welcome they received there, the Elliotts returned with a deep appreciation for lush lawns and the more favorable food prices in Des Moines.

Health Is an Individual Responsibility

The following material has been written by Mrs. R. C. L. Robertson, the 1970-71 president of the Woman's Auxiliary to the American Medical Association.

It has been said: "A complete concept of health is maximum well-being through sound, healthful living habits and full use of the capabilities thus made possible. For the individual this means a state of feeling well in body and mind and an attitude which regards health not as an end in itself but as the means of more constructive service to mankind."

This statement could be used as the reason for the Auxiliary's new "Physical Fitness" project.

Each individual is responsible for his own health. Each individual decides what foods he eats, what exercise he takes, what he does in regard to the health hazards of smoking or drinking, and whether he avails himself of proper health supervision such as seeking medical care when it is needed and having periodic medical check-ups.

This responsibility for one's health cannot be legislated. No agency at local, state or national levels can guarantee health. However, health education can make individuals aware of their responsibility and inform people how to obtain and maintain good health. This has been one of the primary functions of the medical auxiliaries. The National Auxiliary package programs, available through national headquarters, offer a golden opportunity to provide health education.

It is hoped by becoming interested in programs and projects to make themselves physically fit, auxiliary members will motivate their husbands and families to become concerned about fitness. They then will exemplify to the people of their communities proper health habits.

We can do our part in our communities by helping educate people to what no one else can do for them—take care of their health.

Governor's Drug Abuse Conference

Mrs. K. M. Chapler of Dexter attended the Governor's three-day Drug Abuse Conference at Veteran's Memorial Auditorium in Des Moines last Spring at the personal invitation of Governor Robert D. Ray. This was the first state conference of this type in the United States.

A myriad of agencies, organizations, and professions were represented at the meeting. Mrs. Chapler is serving a second year as President of the Dallas-Guthrie County Medical Auxiliary. The meeting was financed by the State Health Department at a cost of $5,000.

Four months ago, Dr. Phillip J. Levine, associate professor of pharmacy at Drake University, was appointed the Governor's Consultant on Drug Abuse Programming. He and Mrs. Mary Filk of the Iowa Office of Economic Opportunity were in charge of the conference.

Mrs. James Atwater of Washington, D. C., Special Assistant to President Nixon, brought a special message from the President.

Mr. Tom McManus, a youthful former drug addict, spoke provocatively of his experiences in helping other young people "kick the habit." His mother, Mrs. Mary Anne McManus, described her experiences with her son and how she handled them.

The topic discussed by Allan Y. Cohen, Ph.D.,

Clinical Psychologist and Associate Professor of Clinical Psychology at John F. Kennedy University, Martinez, California, was "Education vs. Information." Dr. Cohen has travelled over 100,000 miles relating his work with young people and drugs on campus.

Frank Haendel, M.D., a psychiatrist with the Drug Dependence Treatment Unit, Boston, Mass., discussed "Outpatient Care" with emphasis on heroin users.

The federal and regional agency representatives on drug abuse programming summarized the ways in which funds can be obtained by agencies and communities to combat drug abuse. The limited federal money available comes either from the National Institute of Mental Health or the Model Cities Program of the Office of Economic Opportunity, which is to be phased out in two or three years. The best hope for funding is community planning and financing.

Wednesday was devoted to reports and suggestions from 19 areas in Iowa. Mrs. Chapler is chairman of one seven-county area. Following lunch, Governor Ray spoke briefly to the Conference participants.

Once only a problem of the ghettos, drug abuse in the past five years has infested all strata of society and has created a sub-culture. There is no community in the United States where abuse does not exist. Five billion tranquilizers were consumed in the country last year. Misuse of drugs begins as early as nine years and is found to exist among those to age 85. The current viewpoint is away from the punitive, and is more of an expression of concern for the reasons people turn to drugs, e.g., excitement, euphoria or escape.

Mrs. Chapler is eager to help anyone wishing information regarding books and pamphlets on the drug abuse problem. Write to her at Dexter, Iowa, 50070.

Meet . . .

Trudy Beattie, Vice Chairman, Republican 4th District

"I believe that strength depends not so much upon where we stand, but in what direction we are moving. I pledge continuous dedication to building and maintaining the kind of organization that moves forward!"

This assertion was made by Trudy Beattie before her July 25 election as Vice Chairman of the Fourth District at the State Republican Convention.

The new Vice Chairman is the wife of John L. Beattie, M.D., a surgeon with the Creston Medical Clinic. The Beatties live in Creston and have two children: Rick, 16, a junior at Wentworth Military Academy; and, Kristi, 14, a freshman at Creston Junior High.



Mrs. John L. Beattie

Mrs. Beattie believes in "Better Government through Republican Strength," and has served her party as Precinct Committeewoman, Union County; Past President, Union County Republican Women; Union County Chairman for Congressman John Kyl; Organizer and sponsor of Kyl Smile Girls; Recording Secretary, Fourth District Republican Women, and State Corresponding Secretary, Iowa Federation of Republican Women.

It has been said, if you want to get a job done—ask a busy woman. Not only has she served her community and state in a number of other ways but she is 1970-71 Chairman of the Legislation Committee of the Woman's Auxiliary to the IMS.

The Auxiliary congratulates Trudy on her estensive efforts and wishes her well in the new duties she has assumed.

From Foreword of 1970-71 Workbook

Good auxiliary programs are the result of good planning. Planning can be done best in a working partnership between national, state and county auxiliaries. Not all auxiliaries can participate in every project. Auxiliaries should choose the ones that meet the needs of their respective communities.

Your programs and projects show the auxiliary in action and portray to your community your interest and concern for the good health of your people. It is my sincere wish that with all of us working together, 1970-71 will be a productive and rewarding year, and that through the efforts of our auxiliary members we will come nearer to reaching the goal of positive good health for all of us.

MARJORIE ROBERTSON
President 1970-71
Woman's Auxiliary to the
American Medical Association

An Election Admonition

"The social planners" are poised with loaded hypodermic needles, aiming to sedate the nation with the deadliest drug of all—completely socialized medicine.

The "cradle to grave" health plan introduced by Senator Edward Kennedy would rob the occupants of the nation's cradles and send the private sector of medical care to an early grave!

Assembly-line-medicine can't happen here in the land of the free? Oh, yes it can. And the battle will be fought, won or lost on the political front. **NOVEMBER ELECTIONS ARE CRUCIAL ON ALL LEVELS!**

Some of us have been fighting for a long time. We beg for your help. We need you, and you *and* YOU! *We need every physician, every physician's wife, every child and every friend. Tomorrow is too late. Our freedom is at stake!*

What can you do? First, be informed. Know the candidates. Ask about their stand on issues that vitally concern us. Ask how they feel about the AMA's Medicredit proposal, the Health Insurance Assistance Act of 1970 (H.R. 18567). Help the candidates of your choice any way you can. They need campaign workers. They need money. Campaigns are expensive. Group donations are particularly effective, appreciated and remembered by candidates. If your physician has not yet joined IMPAC, do him a favor, send in his membership contribution right now.

Most of all, your favorite candidates need your vote, plus every vote you can influence or help bring in. A new election law allows hospital patients to vote, by absentee ballot, if they enter the hospital within five days of election day. Ask your political county chairman how you can help these patients vote. Volunteer! Fight!

REMEMBER, the medical care being prepared for the American people is not destined to be administered by the medical profession!

TRUDY BEATTIE
Legislative Chairman

The Planners' Goal . . .

The following thoughts are expressed in an editorial which appeared in the May 25 issue of the AMERICAN MEDICAL NEWS. *They are worthy of reflection as we contemplate the future generally and the November 3 elections particularly.*

"After laying low for two decades, during which they sought to get the camel's nose in the tent through the enactment of Medicare, these advocates of socialized medicine are again out in the open in full force, using as their appealing argument the recent large increases in medical care costs. As propagandists, they are quite willing to ignore and leave unmentioned several significant and crucial facts."

These words by the Social Security Administration's chief actuary, Robert Myers (since resigned), provide—for anyone who hasn't noticed a revealing exposition of the political climate which now surrounds medicine.

Myers, who recently addressed the Oklahoma State Medical Association Convention, said: "The physicians of this country have been neatly trapped by the social planners, who secretly envy their high incomes, whether real or apparent, and thus criticize them on any possible grounds."

Before Medicare was enacted, its proponents said it was needed because many elderly people, who were being treated at no charge by their physicians, resented being treated as "second-class citizens" and felt it was "demeaning" not to pay their physician.

The medical profession, which had a better idea of the magnitude of this problem than most of the social planners, warned that enactment of Medicare would cost far more than its proponents were saying it would.

These warnings were disregarded, and Medicare was enacted. So, the physicians followed the announced intent of the law and billed Medicare patients at their usual rates. And, just as medicine had warned, the costs were far above the original estimates.

Myers told the Oklahoma doctors: "You can't win." He pointed out physicians are being criticized for billing their patients at usual rates despite the fact that that's what Medicare's proponents thought was so important a few years ago. On the other hand, he went on, if physicians had artificially held down fees for Medicare patients, "the social planners" would have asserted that the program was operating so successfully that it should be extended to the entire population.

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501

President-Elect—Mrs. P. H. Tenney, 203 Second Avenue, SW, Independence 50644

Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312

Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228

Editor of THE NEWS—Mrs. J. L. Kehoe, 111 McClellan Blvd., Davenport 52803

American Association of Medical Assistants

State of Iowa, Inc.

Why a Medical Assistants Association?

With Iowa hosting the National Convention of the American Association of Medical Assistants, it seems to me this is an appropriate time to ask the question: *Why do we have a Medical Assistants Association?*

Fourteen years ago, medical assistants from 15 states met in Kansas City, Kansas, to discuss formation of a national organization. These women shared common interests, they had a desire to share knowledge, to acquire more knowledge and to establish professional standards.

Today the basic objectives set down by AAMA are "To inspire its members to render loyal, more efficient service to the profession and to the public which we serve; to cooperate with the medical profession in improving public relations; to render educational services for our members. This Association in its Constitution declares that it is not, nor shall it ever become a trade union or collective bargaining agency."

In seeking advancement through self-education we found facilities scarce and in many instances non-existent. We established local organizations and invited knowledgeable persons to instruct us in areas where we felt inadequate. Through our state and national associations we accelerated our programs through workshops, symposiums and college courses.

At one time the medical assistant was drawn almost exclusively from the ranks of hospital personnel, these people had experience with patient care and medical problems. The assistant doubled as receptionist and bookkeeper—in the days when there were no insurance problems, no industrial cases, or even income tax forms! The assistant's duties were mainly of a nursing nature adapted to an office-type practice. She worked only for the doctor-employer. There was no need to understand and complete Medicare and Medicaid forms, in addition to hundreds of private insurance forms covering not only the doctors' services but loss of time, mortgage payments, etc. The day is long past when "pleasing personality to greet patients, make appointments, answer the phone, do some typing," was the job description for employment in a physician's office.

Today's medical assistant works with the physician as a member of the health team. She is skilled and knowledgeable. Membership in a professional organization such as AAMA helps her develop a sense of confidence and provides her the knowledge to handle the problems which arise in the physician's office or clinic.

AAMA is a personal organization—it identifies you. It tends to widen your horizons in many ways, it puts you in contact with other medical assistants to exchange ideas and it gives you the opportunity to expose your own ideas among knowledgeable persons and see them implemented. A professional organization can provide you the opportunity to develop leadership and it keeps you informed. Scientific and educational programs especially for you are sponsored by the local and state group, and by the AAMA. The programs, seminars, State and National Conventions, workshops, and study groups are all stimulating experiences. You receive a by-monthly professional journal, and are entitled to wear an AAMA pin and to participate in the AAMA group insurance programs.

The AAMA has over 12,000 members with chapters in Hawaii, Alaska, and Puerto Rico—in all states but three, and these AAMA members are among the most informed paramedical personnel in the nation.

Come to Des Moines and take part in our AAMA Convention—October 28-31, 1970—you'll be glad you did!

JEANNE D. GREEN

The AAMA National Convention Comes to Des Moines October 28-31

We Hope Your Office Will Be Represented!!



Personals



Dr. A. G. Felter, of Van Meter, was honored recently for 50 years of service to that community. Dr. Felter was graduated from the U. of I. College of Medicine in 1920 and interned at Iowa Methodist Hospital in Des Moines. Following his internship he began his practice of medicine in Van Meter. He has served on the Van Meter City Council and was mayor in the late 1920's. Dr. Felter was cited particularly for helping many Van Meter young people with their college educations. He is a life member of the Iowa Medical Society, an honored member of the American Medical Association and has been a governor for the past three years of the American College of Cardiology. He has not missed an International Heart Congress since the first one in 1950. **Dr. Perry Weigel,** who practices with Dr. Felter, began working with Dr. Felter as a youth, driving him on house calls in rural areas and to the hospital.

Dr. Charles R. Argo has joined **Drs. Robert M. Collison, Sidney A. Smith** and **James L. Smith** at the Family Medical Center in Oskaloosa. For the past two years Dr. Argo has been with the Public Health Service on the Colville Indian Reservation in Nespelem, Washington. A native of Moravia, he was graduated from Central College in Pella in 1963 and received the M.D. degree at the U. of I. College of Medicine in 1967. Dr. Argo served his internship in Spokane, Washington, before becoming associated with the Public Health Service.

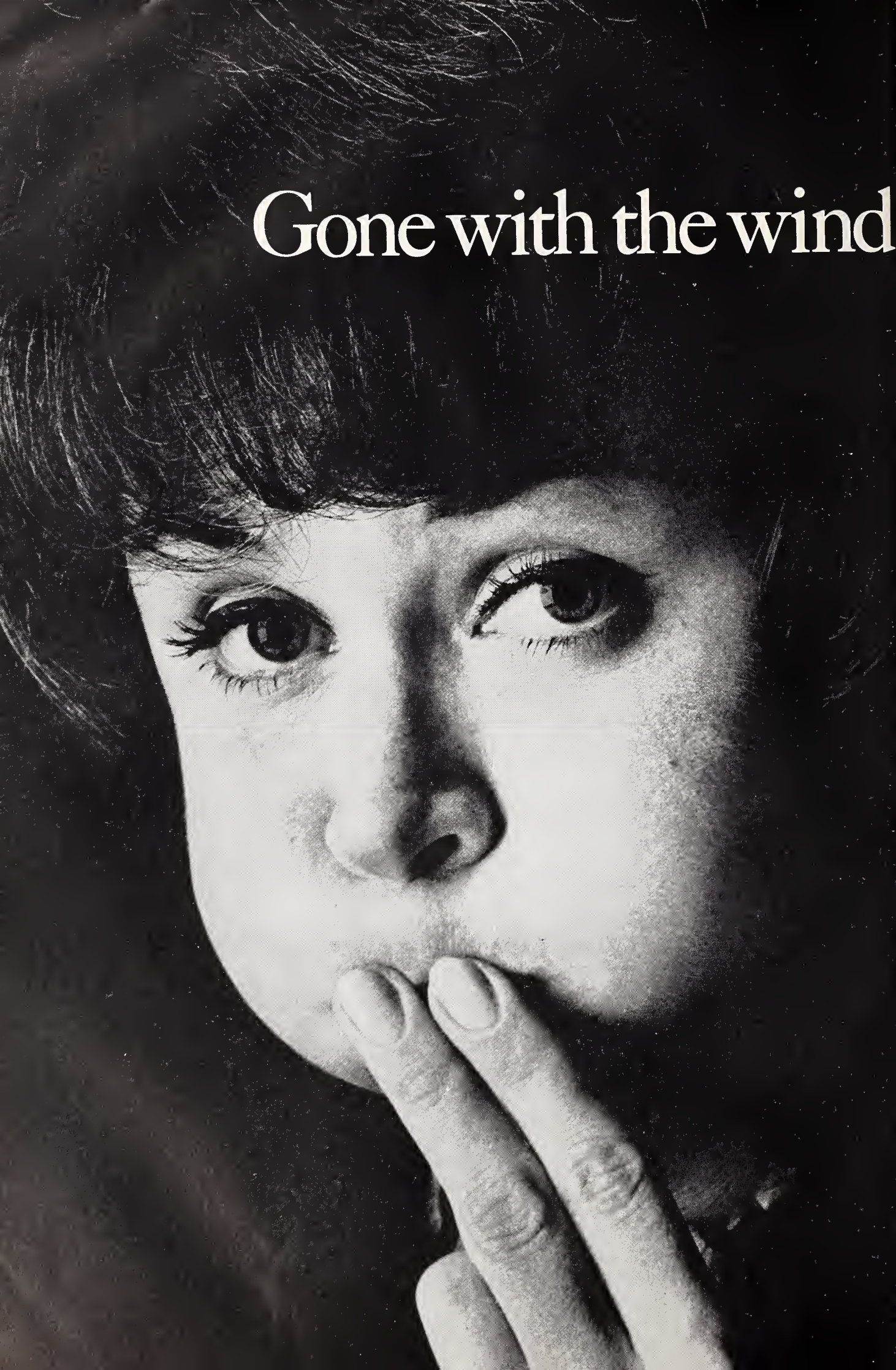
Dr. Donald J. Ahrenholz, of Cedar Falls, has been named surgeon for Eldora Community Hospital. Dr. Ahrenholz will do surgery in Eldora one day a week. He is regularly a surgeon at Sartori Memorial Hospital in Cedar Falls.

Dr. George Montgomery has taken a leave of absence from the McFarland Clinic in Ames to do a year of medical missionary work in a hospital for Zulus in Natal Province of South Africa. The 200-bed hospital, run by the Lutheran Medical Foundation, cares for patients with tropical diseases and tuberculosis—all from the surrounding territory of Zululand. Dr. Montgomery is a specialist in internal medicine. Mrs. Montgomery, who is a registered nurse, will accompany him.

Dr. Daniel M. Keller has joined **Dr. Clark W. Stevens** in the practice of obstetrics and gynecology at Medical Associates in Dubuque.

Dr. Philip S. H. Pugh, a native of Sioux City, has opened an office for the general practice of medicine at 1101 Army Post Road in Des Moines. Dr. Pugh received the M.D. degree at the U. of I. College of Medicine in 1969 and interned at Iowa Methodist and Broadlawns Hospitals in Des Moines.

Dr. Donald F. Rodawig, of Spirit Lake, was honored recently at an open house for his 40 years of medical and surgical service to the citizens of that community. Dr. Rodawig was graduated from the U. of I. College of Medicine and completed his internship at Henry Ford Hospital in Detroit, Michigan, and his surgical residency at Lucas County Hospital in Toledo, Ohio. He began his practice in Spirit Lake in 1930. Assisted by the late Dr. Phil A. Scott, Dr. Rodawig established the Marcus Snyder Memorial Hospital. When Dickinson County Memorial Hospital was opened Dr. Rodawig closed the private hospital and converted it into the Spirit Lake Medical Center which is now operated by his son **Dr. Donald F. Rodawig, Jr., Dr. Carol L. Plott** and **Dr. Maurice Kirlin.** An active participant in community activities, Dr. Rodawig was named "Citizen of the Year" in 1960 by the Kiwanis Club. He was a founding member and first president of the Spirit Lake Rotary Club. Forced by personal health reasons to seek a less rigorous climate and a limited practice, Dr. Rodawig and Mrs. Rodawig are moving to Tempe, Arizona, where Dr. Rodawig will become a part-time member of the staff at the Student Health Center at Arizona State University.


Gone with the wind

Dr. Charles Bendixen has joined **Dr. Arthur Cloud** in the practice of medicine at Marshalltown. A 1966 graduate of the U. of I. College of Medicine, Dr. Bendixen served his internship and one year of general surgery residency at Akron City Hospital in Akron, Ohio. He has just completed serving two years as a flight surgeon in the Air Force at Holloman AFB, New Mexico.

Dr. John E. Evans, of Winterset, recently appointed to the Madison County Board of Health, was named vice-chairman of the Board at its July meeting.

Dr. Robert E. Durnin, assistant professor in the Department of Pediatrics at the U. of I. College of Medicine, gave a presentation on distinguishing heart sounds for the Iowa Regional Medical Program at the Floyd County Memorial Hospital. Dr. Durnin explained the system of using heart sounds to detect various heart disorders.

Dr. Charles F. Hesse has joined the obstetrical-gynecological practice of **Dr. Lowell Luhman** and **Dr. Stanley Greenwald** in Iowa City. Dr. Hesse has completed residency training in obstetrics and gynecology at the U. of I. College of Medicine. He received the B.S. degree from Iowa State University and his M.D. degree at the U. of I. He interned at Emanuel Hospital in Portland, Oregon.

Dr. Louise M. Camel, of Council Bluffs, has been chosen honorary chairman for the medical profession section of the 1970 Pottawattamie County Muscular Dystrophy fund drive.

Dr. Richard O. Emmons, of Clinton, was the guest speaker at a recent meeting of the Clinton Rotary Club. Dr. Emmons spoke on intensive coronary care.

Dr. Glenn Van Roekel, who will complete his residency in radiology at the U. of I. College of Medicine on October 1, has accepted the position as head radiologist at Floyd Valley Hospital in LeMars.

Dr. Charles J. Baker, a Fort Dodge pediatrician since 1939, has joined the Arizona State University Health Service at Tempe, Arizona. Dr. Baker was graduated from the Cornell University Medical School in 1932 and served his internship and residency at a Brooklyn, New York, hospital. After practicing in Brooklyn for a year, he came to Fort Dodge. Dr. Baker has served on the Webster County Board of Health, in various offices of the Webster County Tuberculosis and Health Society and on the board of Blue Shield for six years. He is a past president of the Webster County Medical Society.

Dr. Sidney Sands, director of Medical Education and Psychiatric Services for Broadlawns Hospital in Des Moines, was a guest speaker during an August Drug Education Workshop at Drake University.

Dr. Montague S. Lawrence, professor of cardiovascular and thoracic surgery at the U. of I. College of Medicine, spoke at a recent meeting of the Linn County Unit of the Iowa Heart Association held at St. Luke's Hospital in Cedar Rapids.

Dr. Terry Dynes, a Decorah physician, has been elected president of the Winneshiek County Physical Therapy Center, Inc. The Center is located in Decorah.



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Dr. Dohn R. Kruschwitz has joined **Drs. G. D. Button** and **R. K. Patterson** in the practice of medicine at Conrad. A native of Grundy Center, Dr. Kruschwitz received the M.D. degree at the U. of I. College of Medicine in 1966 and served his internship and a general practice residency at Broadlawns Hospital in Des Moines. He recently finished two years of Alternative Civilian Service at Hospital Castaner, Castaner, Puerto Rico.

Dr. Ada Perel Gaskill, a Des Moines psychiatrist, has been named medical director of the newly incorporated Poweshiek County Mental Health Center. Dr. Gaskill will serve the Center part time in the Grinnell Hospital offices and will continue her private practice in Des Moines. A 1948 graduate of Indiana University School of Medicine, Dr. Gaskill served her internship at Methodist Hospital in Indianapolis and completed her three-year residency in psychiatry at the Psychopathic Hospital in Iowa City.

Dr. Donald G. Bock, a Fort Dodge internist, spoke at a recent meeting of the Wright County Medical Society. Dr. Bock discussed phenotyping.

Dr. Dale Harding, of Eagle Grove, is the newly elected chairman of the North Central Stroke Advisory Committee of the Iowa Heart Association. Dr. Harding was a member of the original committee which initiated and put into operation the pilot project in 1966. He succeeds **Dr. H. W. Beard,** of Mason City.

Dr. Terry J. Sutton has joined the staff at the Fairfield Medical Arts Clinic. A native Iowan, Dr. Sutton received the M.D. degree at the U. of I. College of Medicine in 1966. He served his internship at a Cedar Rapids hospital and then spent a year in a general surgery residency at Grosse Pointe, Michigan, before entering the service. Dr. Sutton has just completed two years in the U. S. Air Force.

Dr. Darrell Fisher has returned to Mason City, his home town, and is affiliated with Surgical Associates as an orthopedic surgeon. Dr. Fisher received the M.D. degree at the U. of I. College of Medicine in 1961, interned for a year at Iowa Methodist Hospital in Des Moines and was a medical officer at the Naval Station Dispensary in Pearl Harbor from 1962 to 1965. From 1965 to 1966, Dr. Fisher was with Surgical Associates as a preceptor in surgery. In June of this year he completed his orthopedic surgery residency at the Mayo Clinic in Rochester.

Six faculty members of the U. of I. College of Medicine participated in the Tenth International Congress for Microbiology held in Mexico City. Participating from the Department of Microbiology were **Drs. John R. Porter,** professor and head of the department; **Irvin S. Snyder,** associate professor; and **George E. Becker** and **Jose E. Rodriquez,** both assistant professors. Presenting research reports from the Department of Internal Medicine were **Drs. Ian M. Smith,** professor, and **Sergio Rabinovich,** associate professor. Dr. Porter presided at a scientific session and served as a U. S. delegate to a colloquim on the de-escalation of biological warfare. He is a member of the executive advisory committee of the International Association of Microbiological Societies, which consists of national societies in 45 nations. Drs. Snyder and Becker served as discussants at scientific sessions and Dr. Rodriquez presented a report on "Post-infection Inhibition of NDV Replication by Interferon" at a session on virology. Dr. Smith spoke on "Microbial Aspects of Infectious Diseases in a U. S. Referral Hospital" and Dr. Rabinovich presented a paper on "The Effect of Salicylates and Other Agents in Influenza Infections."

Dr. N. E. Weems, of Paullina, was honored recently at an open house by the local citizenry in recognition of his 50 years of devoted work and service in the practice of medicine in Paullina and the surrounding area. Dr. Weems came to Paullina in 1919 following his graduation from the U. of I. College of Medicine.

Dr Charles E. Hartford, assistant professor of surgery at the U. of I. College of Medicine, presented a paper on "Five-Year Experience With Silver Nitrate in the Treatment of Burns: Comparison With Former Methods of Therapy," at the third International Congress for Research on Burns in Prague, Czechoslovakia.

Dr. Robert W. Kent, of Tipton, recently participated in an advanced workshop of the American Society of Clinical Hypnosis in Chicago. He has also just completed a postgraduate course in psychiatry at the Psychopathic Hospital in Iowa City.

Dr. John W. Billingsley, a Newton physician since 1920, has been reappointed by **Governor Robert D. Ray** to the State Board of Medical Examiners.

Dr. F. J. Swift, a Maquoketa physician for 25 years, has moved to Gainesville, Florida, where he will be on the staff of both the Veterans Administration Hospital and the University of Florida Hospital.

Dr. Robert Shultice, a Cedar Rapids psychiatrist, has been named medical director of the Linn County Mental Health Center. Dr. Shultice succeeds **Dr. Thomas Murphy** who moved recently to Philadelphia.

Deaths

Dr. Edgar S. Brintnall, 56, a clinical professor of surgery at the U. of I. College of Medicine, died at the VA Hospital in Iowa City on July 15. A native of Winthrop, Dr. Brintnall took his premedical training at the University of Northern Iowa and received the M.D. degree at the U. of I. College of Medicine in 1938. After resigning as chief surgeon at the VA Hospital in Iowa City in 1962, Dr. Brintnall practiced surgery at the Eldora Community Hospital and was a member of the Eldora Medical Center staff. He served as a surgeon during World War II and was a retired colonel in the U. S. Army Medical Corps.

Dr. Amos W. Brunk, 74, died at his home in Creston on July 17. Dr. Brunk was graduated from Northwestern School of Medicine in Chicago in 1925. He moved to Prescott in the fall of 1928 and served the medical needs of that community for 42 years. In grateful appreciation, in July, 1958, the citizens of Prescott sponsored a special Dr. Brunk Day. He was a veteran of World War I.

Dr. James B. Blair, 56, of Cherokee, died on August 5 at Methodist Hospital in Omaha following a 10-month illness. Dr. Blair received the M.D. degree at the University of Nebraska School of Medicine in 1940, interned at University Hospital in Omaha and served his surgical residency at Veterans Hospital in Lincoln. He was a major in the Medical Corps during World War II, a fellow of the American College of Surgeons, a member of the Iowa Medical Society and the American Medical Association.

Dr. George W. Cusick, 80, of Davenport, died July 23 after a brief illness. A graduate of the University of Illinois School of Medicine, Dr. Cusick practiced in Freeport, Illinois, and Princeton, Iowa, before coming to Davenport in 1942. He was a past president of the Iowa-Illinois Central District Medical Association and the medical staff of St. Luke's Hospital. He was also a 50-year member of the medical staff at Mercy Hospital in Davenport and trustee of the Scott County Medical Society. During World War I, Dr. Cusick received the French Dijon Medal.

Dr. James H. Taylor, 51, a Clinton orthopedic surgeon since 1954, died at his home August 6. Dr. Taylor was graduated from the U. of I. College of Medicine in 1944 and interned at Billings Hospital in Chicago. He served in the U. S. Army Medical Corps from 1945-47. Dr. Taylor was a member of the Clinton Consistory, the Western Star Lodge A.F. & A.M., the Kaaba Shrine and a past president of the Iowa Orthopedic Society.

Dr. Ben C. Hamilton, 83, of Jefferson, died at the Greene County Hospital August 6 after a short illness. Dr. Hamilton attended the U. of I. College of Medicine and Northwestern Medical School. He served his internship at Cook County Hospital in Chicago and then returned to Jefferson where he started the practice of medicine with his father. In addition to his 60-year membership in the Greene County Medical Society, the Iowa Medical Society and the American Medical Association, Dr. Hamilton was a past president of the Iowa Pediatric Society and the Iowa Clinical Society, and a charter member of the Jefferson Rotary Club and the American Legion.

Dr. A. Fred Watts, 85, a Creston physician for 40 years, died August 17 at Greater Community Hospital in Creston after receiving second and third degree burns in a fire at the downtown apartment where he lived. Dr. Watts received the M.D. degree at the U. of I. College of Medicine in 1916 and served his internship at an Iowa City hospital. He was the Creston city health physician for 35 years, retiring in 1966. A veteran of World War I, Dr. Watts was a member of the American Legion, Za-Ga-Zig Shrine, Iowa Medical Society and the American Medical Association, and a past president of the Creston Kiwanis.

Dr. Ray R. Harris, 86, a retired physician and surgeon in Dubuque, died August 24 at the Dubuque County Nursing Home. A graduate of the University of Illinois School of Medicine, Dr. Harris opened his practice of medicine in Dubuque in 1908. He served in World War I as a surgeon in Georgia and during World War II was the examining physician for the Dubuque Draft Board. Dr. Harris was the first Iowa member of the American College of Surgeons, a past president and lifetime member of the Dubuque County Medical Society, and a past president of the Iowa Clinical Surgeons.

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Thursday, October 1
Council Bluffs (Lakeshore Country Club)

Tuesday, October 6
Davenport (Outing Club)

Thursday, October 8
Burlington (Holiday Inn)

Tuesday, October 13
Mason City (Sheraton Motor Inn)

Thursday, October 15
Boone (Imperial Inn)

Wednesday, November 18
Des Moines (Hyatt House)

Society members are urged to attend the meetings in their area

Index to Advertisers

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Prouty Company 716

Robins, A. H., & Company 726, 726A, B
Roche Laboratories 682B, C, D, 686-687, 736

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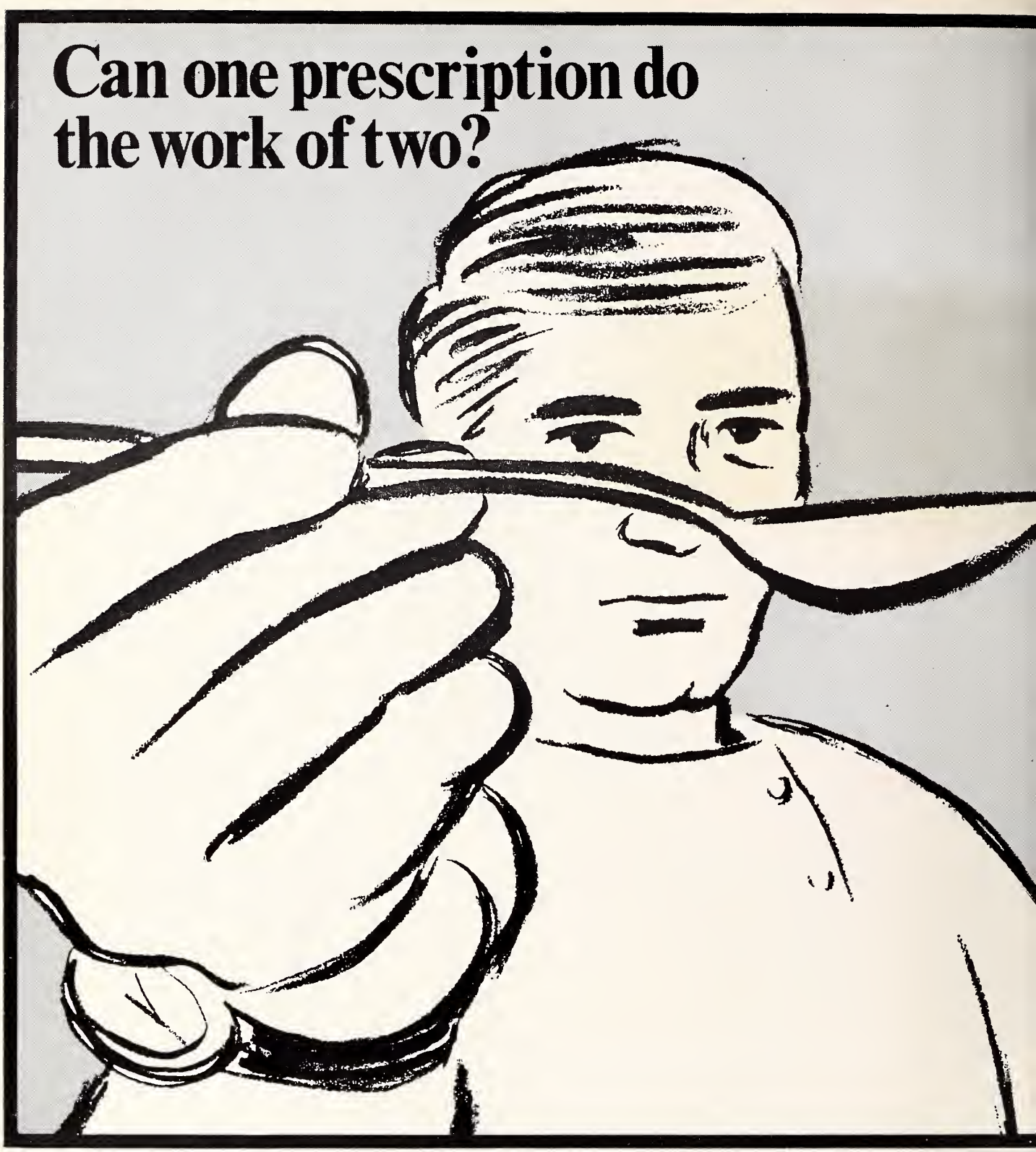
IN THIS ISSUE

- L-Dopa Therapy in Parkinson's Disease (A Year's Experience with 20 Patients)—R. W. Fincham, M.D., and D. A. Decker, Jr., M.D.
- Congenital Nephrotic Syndrome: Case with Electron Microscopic and Family Studies—Bong Sik Han, M.D., and Marion E. Alberts, M.D.
- Indications for Use of Anticoagulants in Stroke Syndromes—John R. Taylor, M.D., and Maurice W. Van Allen, M.D.
- New Drug Legislation—Highlights of Recent Drug Conference



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(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.

The JOURNAL of THE IOWA MEDICAL SOCIETY

Vol. LX NOVEMBER, 1970 No. 11

CONTENTS

SCIENTIFIC ARTICLES

L-Dopa Therapy in Parkinson's Disease (A Year's Experience with 20 Patients)
R. W. Fincham, M.D., and D. A. Decker, Jr., M.D. 755

Congenital Nephrotic Syndrome: Case with Electron Microscopic and Family Studies
Bong Sik Han, M.D., and Marion E. Alberts, M.D. 760

Indications for Use of Anticoagulants in Stroke Syndromes
John R. Taylor, M.D., and Maurice W. Van Allen, M.D. 767

EDITORIALS

Careful Food Handling: A Must 771

Possible Agent in Transmission of Crohn's Disease and Its Similarity to Sarcoidosis . . . 773

Immunization Levels Need Constant Attention . 774

A Hoosier Success 775

Cervical Lymph Node Biopsies 776

SPECIAL DEPARTMENTS

President's Page 744

Medical Meetings 745

Iowa Medical Miscellany 748

State Department of Health 750

In the Public Interest facing page 754

Doctor's Business 777

American Association of Medical Assistants, State of Iowa, Inc. 779

Woman's Auxiliary News 780

Personals 784

Deaths 789

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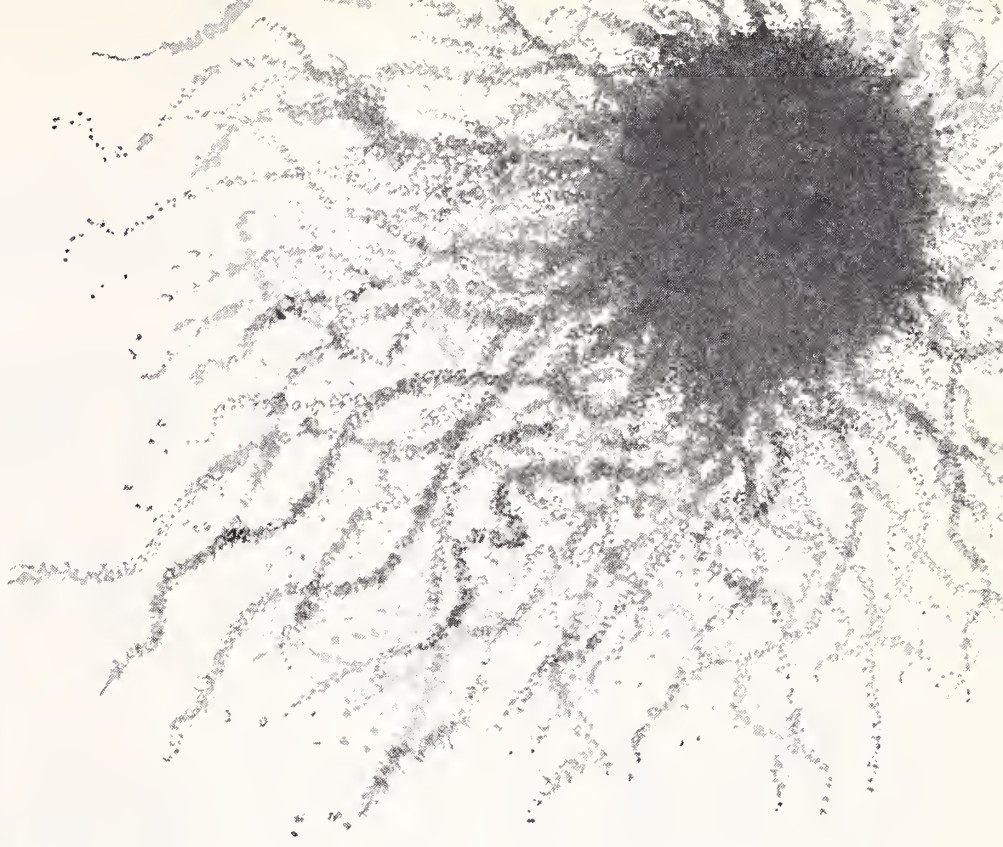
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Daniel F. Crowley, M.D. Des Moines
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Address all communications to the Editor of the Journal, 1001 Grand, West Des Moines, Iowa 50265.

Postmaster, send form 3579 to the above address.



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and monilial overgrowth this week.

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

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Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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rtigo, her palpitations—that's *her*
roblem. What really bothers him is
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er excessive anxiety, often expressed
y endless "book-shuffling, chain-
noking, reading-lamp" insomnia!

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nd water-soluble esterified estrogens.
therefore relieves more symptoms
an either component separately.
takes care of the vasomotor
mptoms as well as the emotional
mptoms. This means the symptoms
at bother his wife most. And the
mptoms that irritate him most.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

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5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
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President's Page



November signals Thanksgiving. In these United States we, as physicians, have much for which to be thankful. In spite of our daily exasperations, we still have a more tolerable practice climate than our colleagues elsewhere in the world.

Our Thanksgiving reflections should include a look to the future—we must strive to preserve that which is good. We still have the opportunity to direct our destiny—others in the world do not. We must demonstrate our leadership in peer review, we must foster continued education. These in combination spell quality medical care.

The profession negates its responsibility to the consuming public when it does not take the lead in guiding health care delivery programs. The Foundation for Medical Care appears to have the ingredients to provide an appropriate mechanism for the profession to use to control its destiny and to assure the consuming public a sound health care delivery system.

May our Thanksgiving prayer include asking for the privilege of leading in the field of our competence.

President

MEDICAL MEETINGS

CONTINENTAL U. S.

Nov. 2-4 **Clinical Reviews presented by Mayo Clinic and Faculty of Mayo Foundation**, Mayo Civic Auditorium, Rochester.

Nov. 2-4 **38th Annual Postgraduate Assembly of Omaha Mid-West Clinical Society**, Fontenelle Hotel, Omaha.

Nov. 2-13 **Postgraduate Course on Clinical Management and Control of Tuberculosis sponsored by University of Colorado School of Medicine**, Denver.

Nov. 2-13 **Postgraduate Course in Laryngology and Bronchoesophagology sponsored by Department of Otolaryngology**, University of Illinois Medical Center, Chicago

Nov. 4-6 **Postgraduate Course on Management and Care of Respiratory Insufficiency sponsored by University of Colorado School of Medicine**, Denver.

Nov. 5 **Postgraduate Course on Role of Nurse in Dealing With Emotional Problems of Patients, University of Nebraska Medical Center**, Yancey Hotel, Grand Island.

Nov. 5-7 **American Society of Cytology**, Biltmore, Los Angeles.

Nov. 6-8 **Congress of County Medical Societies Annual Meeting and Seminar on Private Practice**, Netherland Hilton, Cincinnati.

Nov. 9-11 **Clinical Reviews presented by Mayo Clinic and Faculty of Mayo Foundation**, Mayo Civic Auditorium, Rochester.

Nov. 9-12 **Postgraduate Course in Internal Medicine sponsored by University of Kansas School of Medicine**, University of Kansas Medical Center, Kansas City, Kansas.

Nov. 9-13 **Postgraduate Course on Internal Medicine sponsored by Chicago Medical Society**, Knickerbocker Hotel, Chicago.

Nov. 9-20 **Postgraduate Course in Laryngology and Bronchoesophagology**, University of Illinois Medical Center, Chicago.

Nov. 10-11 **American Heart Association's Council on Arteriosclerosis**, Howard Johnson's Motor Lodge, Atlantic City.

Nov. 11 **Postgraduate Cardiovascular Seminar sponsored by Scientific Councils of American Heart Association**, Shelburne Hotel, Atlantic City.

Nov. 11-12 **Postgraduate Course on Diagnostic Procedures**, Cleveland Clinic Educational Foundation, Cleveland.

Nov. 11-12 **Postgraduate Course in Gastroenterology—Diagnostic Procedures sponsored by Cleveland Clinic Educational Foundation**, Cleveland.

Nov. 11-13 **Postgraduate Course on Genetics for the Internist sponsored by American College of Physicians, New York Hospital**, Cornell Medical Center, New York.

Nov. 11-14 **Fourth Annual Postgraduate Conference on Today's Hospital Problems: An Interdisciplinary Approach sponsored by Mound Park Hospital Foundation and University of Florida's J. Hillis Miller Health Center**, Tides Hotel and Bath Club, Redington Beach, Florida.

Nov. 12-13 **Third Annual Duke Conference on Physician's Assistants sponsored by Duke University Medical Center**, Durham Hotel, Durham, North Carolina.

Nov. 12-15 **43rd Annual Scientific Sessions of American Heart Association**, Convention Hall, Atlantic City.

Nov. 13-14 **Sixth Annual Cornhusker Conference for Surgeons sponsored by University of Nebraska Medical Center**, Lincoln Country Club, Lincoln.

Nov. 13-14 **Postgraduate Course on Otolaryngology for Family Practitioners sponsored by University of Miami School of Medicine**, Sheraton-Four Ambassadors Hotel, Miami.

Nov. 16-19 **1970 Scientific Assembly of Pennsylvania Medical Society**, Host Farm Resort Motel, Lancaster, Pennsylvania.

Nov. 16-20 **Postgraduate Course on Obstetrics and Gynecology sponsored by Chicago Medical Society**, Knickerbocker Hotel, Chicago.

Nov. 18-20 **21st Annual Postgraduate Symposium on Medical Technology sponsored by University of Kansas School of Medicine**, Battenfeld Auditorium, Kansas City, Kansas.

Nov. 19-20 **Diagnostic and Therapeutic Problems in Practice of Pediatric Neurology sponsored by University of Nebraska Medical Center**, Lincoln.

Nov. 19-20 **Seminar in Obstetrics and Gynecology sponsored by University of Florida College of Medicine**, Gainesville, Florida.

Nov. 19-21 **Symposium on Battered Child sponsored by University of Colorado School of Medicine**, Denver.

Nov. 20-21 **Current Concepts in Pathogenesis and Therapy of Kidney Disease sponsored by Upper Midwest and Wisconsin Kidney Foundation**, University of Wisconsin, Madison.

Continuing Education Courses & Conferences

Please call or write Office of Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-4792.

Nov. 6	**Otolaryngology for Otolaryngologist**	**Dec. 2**	**Ophthalmology Clinical Conference**
Nov. 6	**Ophthalmology Clinical Conference**	**Dec. 4**	**Cardiac and Respiratory Disease Conference**
Nov. 19-21	**In-House Conference for Practitioners**	**Dec. 7-10**	**Intensive Coronary Care Management Course**
Nov. 20	**Workshop on Parkinson's Disease**	**Dec. 9-10**	**Postgraduate Course on Obstetrics and Gynecology**
Nov. 20-21	**Sports Medicine**		
Nov. 24	**Refresher Course on Cerebrovascular Disease**	**Dec. 19**	**Refresher Course on Cerebrovascular Disease**

U. of I. College of Medicine

Nov. 20-21	**Workshop on Doctor and His Changing Community sponsored by Institute of Medicine of Chicago,** Ambassador West Hotel, Chicago.
Nov. 20-21	**Postgraduate Course on New Concepts of Coronary Care sponsored by University of Nebraska Medical Center,** Villager Motel, Lincoln.
Nov. 27-28	**Conference on Radiology in Otolaryngology and Ophthalmology,** University of Illinois Medical Center, Chicago.
Nov. 29	**12th National Conference on Medical Aspects of Sports,** Sheraton-Boston Hotel, Boston.
Nov. 29-Dec. 2	**Clinical Convention, American Medical Association,** Boston.
Dec. 5	**Chest Disease Symposium sponsored by St. Luke's Hospital Medical Center,** Mountain Shadows Hotel, Scottsdale, Arizona.
Dec. 5-10	**Annual Meeting of American Academy of Dermatology,** Palmer House, Chicago.
Dec. 7-8	**Symposium on Gynecology and Obstetrics sponsored by University of Kansas Medical Center,** Battenfeld Auditorium, Kansas City, Kansas.
Dec. 7-11	**Seventh Annual Postgraduate Course on Pulmonary Function in Health and Disease sponsored by Louisiana Thoracic Society,** New Orleans.
Dec. 7-11	**Tuberculosis Today sponsored by National Communicable Disease Center,** Atlanta, Georgia.
Dec. 9-10	**Postgraduate Course on Current Concepts in Ophthalmology sponsored by Cleveland Clinic Educational Foundation,** Cleveland.
Dec. 9-10	**Postgraduate Course on Ocular Surgery, Glaucoma and External Disease sponsored by Cleveland Clinic Educational Foundation,** Cleveland.
Dec. 9-12	**Postgraduate Course on Congenital and Acquired Heart Disease in Infants and Children sponsored by American Academy of Pediatrics and Department of Pediatrics, University of Florida College of Medicine,** Happy Dolphin Inn, St. Petersburg.
Dec. 13-14	**Postgraduate Course on How to Detect "Black Lung" Disease sponsored by American College of Radiology,** Brown Palace Hotel, Denver.

ABROAD

Jan. 2-21	**Scientific Winter Cruise Combined with Sectional Meetings sponsored by American College of Surgeons, S.S.** Rotterdam, West Indies, Panama and South America.

Cardiac and Respiratory Disease Conference

The annual Cardiac and Respiratory Disease Conference will be presented Friday, December 4, at University Hospitals in Iowa City. The Conference is co-sponsored by The University of Iowa College of Medicine, the Iowa Thoracic Society and the Iowa Heart Association.

The Conference program is as follows:

8:50 A.M. WELCOME
William R. Wilson, M.D., Professor, Departments of Internal Medicine and Pharmacology

9:00 A.M. POSTURAL HYPOTENSION
Phillip G. Schmid, M.D., Assistant Professor, Department of Internal Medicine

9:30 A.M. SURGICAL TREATMENT OF CORONARY HEART DISEASE
Montague S. Lawrence, M.D., Professor, Department of Surgery

10:00 A.M. OUR DEBT TO WILLIAM HARVEY
John M. Martin, M.D., Clarinda, Iowa

10:45 A.M. CLASSIFICATION & TREATMENT OF HYPERLIPIDEMIA
Arthur A. Spector, M.D., Assistant Professor, Departments of Internal Medicine and Biochemistry

11:15 A.M. ORIGIN OF PHYSICAL SIGNS OF MITRAL & AORTIC VALVULAR DISEASE
John M. Criley, M.D., Chief, Division of Cardiology, UCLA School of Medicine, Harbor General Hospital, Torrance, California

1:30 P.M. PULMONARY ASPERGILLOSIS
Gloria M. Strutz, M.D., Associate, Department of Thoracic Surgery and Cardiovascular Surgery

2:00 P.M. PARAKEET-FANCIER'S LUNG DISEASE
Steven Sahn, M.D., Resident, Department of Internal Medicine

2:30 P.M. SKELETAL TUBERCULOSIS
Paul T. Davidson, M.D., Assistant Professor, College of Medicine, University of Colorado

3:15 P.M. CELLULAR ASPECTS OF IMMUNITY
George B. Mackaness, M.D., Director, Trudeau Institute, Saranac Lake, N. Y.

4:00 P.M. TREATMENT OF BRONCHOGENIC CARCINOMA (A Panel)
John E. Kasik, M.D., Professor, Department of Internal Medicine, Johann L. Ehrenhaft, M.D., Professor and Chief, Division of Thoracic and Cardiovascular Surgery, David T. Kaung, M.D., Assistant Professor, Department of Internal Medicine, and Howard B. Latourette, M.D., Professor, Department of Radiology.

IMS JOURNAL Covers Drug Conference

Read "In the Public Interest" Facing Page 754

How do you make a better cigarette?

Here's how:



Tareyton's activated charcoal
scrubs the smoke to smooth the taste
the way no ordinary filter can.

Put Tareyton's activated charcoal filter on your cigarette, and you'll have a better cigarette. But not as good as a Tareyton.



"That's why us Tareyton smokers would rather fight than switch!"

IOWA MEDICAL MISCELLANY

The Foundation for Medical Care has received a favorable reaction from the majority of those Iowa physicians exposed to it in the past two months. The last of 13 informational meetings on the Foundation concept is set for November 18 in Des Moines. Following this, Society officers will have to determine the next step in the consideration of such an instrument by the medical profession in Iowa. The series of informational meetings has been offered for educational purposes under the combined auspices of the Iowa Medical Society and the Scanlon Medical Foundation/IMS. The November 18 meeting is open to all interested physicians.

* * *

Pursuant to instructions from the 1970 IMS House of Delegates—to formulate "'standards of medical care,' which can be made available to the physicians of Iowa and responsible peer review committees"—the Society's Subcommittee on Medical Review is currently seeking the most prudent means of accomplishing this task. The Subcommittee has been increased to allow for representation by the specialty groups. The Subcommittee met in October and deliberations will continue into 1971.

* * *

Iowa's first physician's assistant has gone to work this fall. Robert Linthacum, M.D., of Dysart, is believed to be the first Iowa physician to employ a person with this designation. The new member of Dr. Linthacum's staff is James E. Bowland, 24, a native of Waterloo. Bowland completed his military service as a medic in June. He served with the Army Special Forces in Vietnam and reportedly delivered 61 babies during his Vietnam service. Bowland has finished three years of premed study at Colorado State and hopes one day to continue his medical education. Under Dr. Linthacum's supervision, Bowland apparently will assist with minor surgery, make nursing home and home calls, do laboratory work, perform routine physical checks on school children, athletes, etc.

"We must remember, after all, that we are dealing with a human animal, his weaknesses, his curiosity, his ingenuity, his predicament and his potential. We cannot spend all our time looking at drugs. We must more urgently look at people who are taking drugs. All of our efforts would be short-sighted indeed if we fail to look beyond drugs to the people who take them." So said Darold A. Treffert, M.D., at the October 7 Conference on Drug Abuse. Approximately 3,000 persons attended the Iowa Health Council program in Des Moines. Dr. Treffert, the keynoter, is Superintendent of the State Hospital in Winnebago, Wisconsin.

* * *

Centennial year reflections: In 1870 The College of Medicine opened its doors to 37 students; interestingly 10 were women. There were nine faulty members. This fall there are 554 students enrolled in The College of Medicine, 454 of whom are residents of Iowa. There are 39 women. The class-by-class breakdown: Seniors—129, Juniors—148, Sophomores—132, Freshmen—145. Reports now are that applications for 1971 admission to the College will exceed 2,000 and establish a new record. Applications last year totaled 1,640.

* * *

IMS Board Chairman K. E. Lister, M.D., Ottumwa, and R. S. Gerard, II, M.D., Waterloo, Chairman of the Society's Subcommittee on Medical Review, appeared October 21 before the Legislative Medicaid Study Committee. The two IMS representatives summarized the Society's peer review activities for the six legislators who serve on this committee. Step-by-step explanations were presented to the lawmakers of three actual peer review cases. Reference was also made to Medical Care Foundation and its potential in the peer review area.

* * *

The large outlay of Iowa Medicaid funds for prescription drugs continues to concern the State Department of Social Services. Approximately 25 per cent (more than the total paid for physicians' services) of the Medicaid disbursements are for drugs. SDSS officials indicate means must be found to curb and reduce this level of expenditure. They urge physicians to provide Medicaid recipients with prescriptions to cover 30-day periods whenever this is medically feasible.

* * *

In recent action the American Academy of General Practice changed its name to American Academy of Family Physicians. The new name will not become official until the fall of 1971 when the Academy's Congress of Delegates meets next.

The Blue Shield Physicians Service Center has stepped up its communications capability with the addition of a new WATS (Wide Area Telephone Service) line. Those physicians' offices desiring information on a particular Medicare, Medicaid, or Blue Shield claim are invited to use this new line. The WATS number is 800—362-2218. Des Moines physicians are requested to use the regular Service Center Number—244-5233.

* * *

Appointment of Robert E. Condon, M.D., as professor and head of the Department of Surgery at The University of Iowa College of Medicine was announced in October. Dr. Condon is a professor of surgery at the University of Illinois and will assume his new post in January. Sidney E. Ziffren, M.D., acting department head since mid-1969, will continue until Dr. Condon arrives. Dr. Condon was graduated from the Medical College at the University of Rochester and has served since at the University of Washington, Baylor University, the National Heart Institute, the Royal Free Hospital in London, and at Illinois.

* * *

The Independence Mental Health Institute has received re-accreditation this fall from the Joint Commission on Accreditation of Hospitals and from the Councils on Medical Education of the American Medical Association and the American Psychiatric Association. The latter covers the institution's three-year psychiatric residency program.

* * *

Those Iowa physicians elected (or re-elected) to membership on the Blue Shield Board of Directors this summer were C. L. Kelly, Jr., M.D., Charles City (District 1), R. C. Larimer, M.D., Sioux City (District 4), C. E. Radcliffe, M.D., Iowa City (District 7), W. A. Fisher, M.D., Creston (District 10), and as physician members at large: J. M. Rhodes, M.D., Pocahontas, W. M. Krigsten, M.D., Sioux City, S. P. Leinbach, M.D., Belmond, and C. W. Seibert, M.D., Waterloo.

* * *

The Iowa Medical Library and the Iowa Traveling Library have formed a central collection agency for drug abuse literature. Physicians desiring information in this area are invited to contact either Mrs. Marion Samo at the Medical Library or Mr. Ron Stump at the Traveling Library.

* * *

James Gannon, M.D., Laurens, has been appointed to the new State Board of Examiners for Nursing Home Administrators. This Board will oversee the required licensure of administrators of all nursing homes. The nine-member Board must include one physician.

What Iowa doctors need is a Malpractice Liability Carrier that won't fade when trouble comes.



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STATE DEPARTMENT OF HEALTH

ARNOLD M. REEVE, M.D., M.P.H., COMMISSIONER

New Drug Legislation

New state legislation relating to the treatment of persons addicted to or dependent on drugs will be of interest to Iowa physicians. A portion of this new statute reads:

"Every medical practitioner or hospital that provides services to a person addicted to or dependent upon drugs, shall each quarter of every year, commencing October 1, 1970, make a statistical report to the Commissioner of Public Health in such form and manner as the commissioner shall prescribe for each such person treated or to whom rehabilitation services were provided during the preceding quarter."

The Department of Health has distributed a letter of explanation to Iowa physicians about the contemplated reporting program. Sent with this letter was a copy of the report form to be used for the quarter ending December 31. Additional information will be furnished by the Department on request.

The new law, entitled Treatment for Drug Addiction (Chapter 1099), is provided for information.

Chapter 1099
Treatment for Drug Addiction

SECTION 1. For the purposes of this Act, unless the context clearly indicates a contrary intent:

1. "Medical practitioner" means a physician and surgeon or osteopathic physician and surgeon licensed to practice medicine in this state.

2. "Hospital" means a public or private hospital licensed pursuant to the laws of this state or any employee, agent, or representative thereof. "Hospital" includes a public agency or a nonprofit agency or corporation providing treatment or rehabilitation services and any employee, agent, or representative thereof, if the commissioner of public health has previously approved the program of treatment or rehabilitation services offered by such public agency, nonprofit agency or corporation.

3. "Drug" means a narcotic drug as defined in section two hundred four point one (204.1), subsection ten (10) of the Code, and a depressant or stimulant drug as defined in chapter one hundred eighty-nine (189), section one (1), subsection six (6), Acts of the Sixty-second General Assembly. For the purpose of this Act the provisions hereof shall be applicable to the treatment and rehabilitation of those who are users of glue by means of inhalation, commonly known as glue sniffing.

SEC. 2. A person may request treatment and rehabilitation for addiction or dependency to any drug as defined in section one (1) of this Act, from a medical practitioner or a hospital and such medical practitioner or any employee or person acting under his direction or supervision, or any hospital shall not report or disclose the name of such person or the fact that treatment was requested or has been undertaken to any law enforcement officer or agency; nor shall such information be admissible as evidence in any court, grand jury, or administrative proceeding unless authorized by the person seeking treatment. A medical practitioner or hospital may undertake the treatment and rehabilitation of such person or refer such person to another medical practitioner or hospital for such purpose. If the person seeking such treatment or rehabilitation is a minor, the fact that such minor sought treatment or rehabilitation for such drug addiction or dependency, or that he is receiving such treatment or rehabilitation service, shall not be reported or disclosed to the parents or legal guardian of such minor without his consent, and such minor may

Diabetes Meetings November 18 and 19

A meeting for professionals who work with diabetics—physicians, nurses, dietitians—will be held in four areas of the state on Wednesday, November 18, and Thursday, November 19. The Iowa Regional Medical Program is sponsoring this project and has issued invitations and programs to members of involved disciplines. We urge your attendance. A well-informed up-to-date professional team can offer more effective help to the diabetic than any one person or group working alone.

give legal consent to receive such treatment and rehabilitation.

SEC. 3. A person seeking treatment or rehabilitation for drug addiction or dependency shall first be examined and evaluated by a medical practitioner. Such medical practitioner shall prescribe a proper course of treatment and medication, if needed. The treating medical practitioner may further prescribe a course of treatment or rehabilitation and authorize another medical practitioner or hospital to provide the prescribed treatment or rehabilitation services. Treatment or rehabilitation services may be provided to a person individually or in a group. Any hospital providing or engaging in such treatment or rehabilitation shall not report or disclose to a law enforcement officer or agency the name of any person receiving or engaging in such treatment or rehabilitation; nor shall any person receiving or participating in such treatment or rehabilitation report or disclose the name of any other person engaged in or receiving such treatment or rehabilitation or that such program is in existence, to a law enforcement officer or agency. Such information shall not be admitted in evidence in any court, grand jury, or administrative proceeding. However, any person engaged in or receiving such treatment or rehabilitation may authorize the disclosure of his name and individual participation.

SEC. 4. A medical practitioner may use any drug or medicine which shall be authorized or released by a federal agency or authority with jurisdiction to so act, to treat a person addicted to or dependent on drugs as an inpatient or outpatient or to maintain such person for a reasonable period of time until proper treatment or rehabilitation for such addiction or dependency can be obtained.

SEC. 5. Every medical practitioner or hospital that provides treatment or rehabilitation services to a person addicted to or dependent upon drugs, shall each quarter of every year, commencing October 1, 1970, make a statistical report to the commissioner of public health in such form and manner as the commissioner shall prescribe for each such person treated or to whom rehabilitation services were provided during the preceding quarter. The form of the report prescribed shall be furnished by the commissioner of health and be so designated that a carbon copy will be available which shall be sent quarterly to the narcotics law enforcement division of the state, such report not to include doctor's signature. The name or address of any person treated or to whom rehabilitation services were provided shall not be reported. Such report shall include the number of persons treated or to whom rehabilitation services were provided; the county of such person's legal settlement; the age of such person; the medication prescribed, if any; number of such persons treated as inpatients and the number treated as outpatients; the number treated who had received pre-

(Continued on page 752)

Morbidity Report for Month of September 1970

Diseases	Sept. 1970	1970 to Date	1969 to Date	Most September Cases Reported From these Counties
Brucellosis	7	41	34	Dubuque
Chickenpox	50	4160	3461	Dubuque
Conjunctivitis	18	249	291	Dubuque, Johnson
Encephalitis				
viral	1	3	10	Davis
type unspecified	1	1	3	Fremont
German measles	4	2012	2264	Clay, Des Moines, Hardin, Johnson
Gonorrhea	464	4005	3101	Scattered
Histoplasmosis	3	14	16	Dallas, Polk, Union
Impetigo	69	372	344	Polk
Infectious hepatitis	52	275	304	Pottawattamie
Infectious mononucleosis	29	395	402	Scott
Malaria, imported				
P. vivax	1*	16	11	Linn
Measles	19	1107	334	Black Hawk, Buena Vista
Meningitis				
echo 3	2	4	0	Clinton, Muscatine
viral	2	5	6	Cerro Gordo, Worth
type unspecified	1	12	17	Pottawattamie
Meningo-encephalitis	1	6	5	Butler
Mumps	55	2345	3993	Black Hawk, Cedar, Dubuque, Marshall
Pneumonia	50	670	352	Scott
Rabies in Animals	8	79	71	Scattered
Rheumatic fever	1*	42	29	Keokuk
Rocky Mountain Spotted Fever	1*	2	8	Humboldt
Salmonellosis				
S. blockley	1	3	3	Linn
S. bredeney	2	3	0	Dubuque
S. enteritidis	3	5	1	Pottawattamie, Woodbury
S. java	1	2	2	Black Hawk
S. newport	2	4	15	Polk
S. schwarzengrund	1	1	0	Woodbury
S. thompson	1	3	1	Allamakee
S. typhimurium	1	20	28	Webster
S. typhimurium var. copenhagen	2	4	8	Mahaska, Woodbury
Shigellosis				
S. flexneri	1	4	3	Muscatine
S. sonnei	13	60	64	Scattered
Streptococcal infect.	310	4910	3257	Johnson
Syphilis	40	397	536	Scattered
Tuberculosis, active	10	101	90	Scattered
Whooping Cough	2	17	7	Polk, Scott

* delayed

vious treatment or rehabilitation services; the number of such persons who maintained their employment while receiving treatment or rehabilitation services; the number of such persons who themselves or their family received public assistance during such treatment or rehabilitation and the type of public assistance received; and any other data required by the commissioner. If treatment or rehabilitation services are provided to a person by a hospital, public agency, nonprofit agency or corporation, such hospital, agency or nonprofit corporation shall coordinate with the treating medical practitioner so that the statistical reports required in this section shall not duplicate one another. The commissioner shall cause all such reports to be compiled into quarterly reports which shall be a public record. The names and addresses of the reporting medical practitioners or hospitals shall not be a public record unless authorized by the person or entity filing the report.

SEC. 6. Section two hundred four point one (204.1), Code 1966, subsection nine (9), is amended by inserting in line one (1) after the word "Means" the word "sale."

SEC. 7. Any person who violates any provision of this Act, shall, upon conviction, be fined not exceeding one hundred dollars, or imprisoned in the county jail not exceeding thirty days.

* * *

The statutory definitions of a narcotic drug and a depressant or stimulant drug will be presented in the Department of Health section of the December JOURNAL.

Operation MEDIHC

The ratio of persons requiring health care to those eligible to provide such care has increased sharply during the past decade. The matter of health manpower has become a nationwide concern. One possibly overlooked source of help is represented by the approximately 30,000 servicemen and women who are discharged each year after having had military training and experience in the health field.

The U. S. Departments of Defense and Health, Education and Welfare have devised a plan which (1) is aimed at easing the health manpower shortage, and (2) is intended to help discharged servicemen and women find civilian jobs and/or training in allied health fields.

This plan is called *OPERATION MEDIHC—Military Experience Directed Into Health Careers.*

Iowa was one of the first states to participate in the program. On May 4, 1970, Arnold M. Reeve, M.D., Commissioner of Health for Iowa, appointed Donald O. Anderson, Director of the Department's Information and Education Division, to serve as State Coordinator for OPERATION MEDIHC.

Information on the program has been distributed to the superintendents of the Area Vocational-Technical Schools and Community Colleges in the state, as well as to 13 medical laboratories. The support of these institutions has been helpful in acquainting Iowans with the program.

Those eligible to participate in the program include servicemen and women:

(1) who are being separated from the service;

(2) who are 90 days or less away from completing their tour of duty, and

(3) who are interested in pursuing a civilian career in allied health fields.

The program operates as follows:

(1) Each serviceman or woman receives an application form from his/her Transition Officer. The application is filled out and sent to the OPERATION MEDIHC Coordinator in his/her state;

(2) Immediately after receiving the application a letter of acknowledgement and a kit are sent to the applicant. The kit includes a list of health facilities in Iowa seeking paramedical help, a list of Area Colleges and the health instruction programs they offer, and a list of hospitals offering training courses;

(3) The serviceman or woman is invited to contact personally the health facility of his choice;

(4) It is also urged that each military applicant, at his convenience, arrange an interview with the Coordinator, and

(5) When job openings are received by the Coordinator the qualifications of the various applicants are examined and matched with the job opportunity, this information is then sent to the facility administrator.

The health occupation categories where openings exist at this time include:

(1) Administrative, Clerical;

(2) Library and Health Records Personnel;

(3) Hygienists and Therapists;

(4) Mental Health, Health Specialists, Social Scientists, Social Workers;

(5) Sanitarians and Environmental Engineers, and

(6) Technologists, Technicians and Assistants.

Many returning servicemen and women are applying for positions which provide for on-the-job-training. Financial help including scholarships may be arranged by the veteran and his employer. Veteran benefits under the G.I. Bill are available which allow a month-and-a-half educational pursuit for each month on active duty after January 1, 1955, up to a maximum entitlement of 36 months.

Some applicants have expressed interest in a physician's assistant position. To date, the Departments of Defense and Health, Education, and Welfare have not included such a course for Iowa. The state of Washington has been designated as a pilot state for this program. Their results may determine the assignments in other states.

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Scientific Articles

L-Dopa Therapy in Parkinson's Disease (A Year's Experience With 20 Patients)

R. W. FINCHAM, M.D., and
D. A. DECKER, JR., M.D.
Iowa City

PARKINSONISM IS A SYNDROME of progressive muscular rigidity, slowness of movement, and resting tremor. Individual variations are seen in the prominence, or even in the presence of these and other neurologic changes. The rate of progression of the syndrome varies widely. Etiologies are several and include the most common idiopathic type, a post encephalitic variety, a drug induced syndrome (phenothiazines, reserpine, . . .) and other less common causes. Until recently therapy has been largely limited to the use of anti-cholinergic and anti-histaminic preparations. These drugs have been helpful to some patients, but as the illness progresses their effectiveness lessens. Recently, the anti-viral drug amantadine hydrochloride (Symmetrel®) has shown some promise in the treatment of Parkinsonism.[1]

This article will summarize our clinical experience with the use of Larodopa* in the treatment of 20 patients with Parkinson's Disease. Some of the patients have been under treatment for a full year and some for only a few months.

THEORY OF DRUG ACTION

The mode of action of L-Dopa is not yet understood, but the following comments may be helpful in understanding the rationale of its use. Degeneration and depigmentation of the pigmented neurons of the upper brain stem appear to be the only consistent neuropathologic finding in the syndrome of either idiopathic or post viral Parkinsonism. This depigmentation reflects a loss of melanin containing neurons. Hence it could be that L-Dopa, a chemical precursor in the formation of melanin, might have some significant role in this illness. In 1960 chemical analysis of the brains of Parkinsonian patients showed the neostriatum (caudate and putamen) and substantia nigra to be virtually devoid of dopamine. A dopaminergic pathway of small diameter fibers was identified in 1964 by means of fluorescence histochemistry which was shown to connect the substantia nigra to the neostriatum. A diseased substantia nigra, such as is found in patients with Parkinsonism, could account for the demonstrated decreased amount of neostriatal dopamine.

* Hoffmann-La Roche brand of Levodopa (L-Dopa) (3, 4-dihydroxyphenylalanine).

Dr. Fincham is an associate professor in the Department of Neurology at the U. of I. College of Medicine. Dr. Decker is a third-year resident in neurology.

Dopamine does not cross the blood brain barrier, but its immediate chemical precursor (L-Dopa) can do this. This drug was first tried in the early 1960's for the treatment of Parkinsonism but the intravenous doses used were too small and were used too briefly to show clearly beneficial clinical effect.[2] It was not until Cotzias began to use large amounts of D-LDopa that impressive therapeutic results began to appear.[3] It is most likely inaccurate to take the simplistic view that the Parkinsonian syndrome will be corrected by replacing a depleted central neurotransmitter, dopamine, with its precursor L-Dopa. There is, however, valid empirical evidence that this drug can be most helpful in the treatment of Parkinsonism.

CANDIDATES FOR L-DOPA THERAPY

Not all of our Parkinsonian patients responded to L-Dopa therapy. Two patients with long standing illness who were confined to bed could not be persuaded to get up even though there was some evidence of lessening rigidity. Three patients (two with previous psychotic episodes) developed increasing confusion, depression and disorientation which required discontinuation of the drug. Another patient who was nearly mute and immobile regained his ability to walk but showed little improvement in mental function.

All of the patients included in our study were carefully screened for a number of problems. Patients with uncompensated endocrine, renal, hepatic, cardiovascular, or pulmonary disease were excluded from therapy as were patients with severe psychoneuroses or psychoses, blood dyscrasias, malignancy, and narrow angle glaucoma. The drug should not be given when sympathomimetic amines are contraindicated, nor should it be given with monamine oxidase inhibitors. In the latter instance, the drug should be discontinued two weeks prior to L-Dopa therapy.

An arbitrary decision was made not to exceed a total daily dose of 4 gms. of L-Dopa, in an effort to avoid the movement disorders which have been reported as prominent, and which have sometimes caused incapacitating side effects. This decision has apparently been a sound one for only one patient has developed a significant dyskinetic syndrome. Some patients have been given less than the maximal daily dose of 4 gms. for various reasons and have nevertheless realized significant improvement. Our lowest daily dose presently is 2 gms. per day. No inhibitors for Dopa decarboxylase were used in this study.

A variety of dosage schedules have been used, but our usual program is as follows:

Days 1 and 2: 250 mg. t.i.d.
Days 3 and 4: 500 mg. t.i.d.
Days 5 and 6: 500 mg. q.i.d.

This is followed by 500 mg. increments every two days until the maximal dose of 4 gms. is achieved.

Individuals who have experienced early nausea or vomiting have necessarily received much smaller doses and these have been increased slowly over much longer periods of time. In this circumstance we have used 125 or 250 mg. increments every other day. Cotzias has recommended the use of much smaller increments (0.3 gm. every 2 days) over much longer periods (6 weeks or longer) with seven separate doses being administered daily. When the patient can not be followed closely, a schedule of 250 mg. increments every second or third day will afford the lowest incidence of side effects.

Since gastric distress is a common complaint, we have given the medication at meal time and with a snack—commonly milk. One patient who had a particularly good response to the drug and was taking 4 gms./day was watched for four days while she deliberately took the medication between meals and without snacks. She had only mild nausea. No change in the effectiveness of the drug was apparent.

It has been reported that pyridoxine hydrochloride (Vitamin B_6) can reverse the anti-Parkinsonian effect of L-Dopa. Ten of our patients received single oral doses of 50 mg. of pyridoxine after a state of therapeutic effectiveness had been established; they showed no remarkable changes in their clinical state following this. We have nevertheless urged patients not to take Vitamin B_6 while receiving L-Dopa.

Several recent reports have discussed the value of L-Dopa therapy in Parkinson's Dis-

ease from the vantage point of double blind studies.[4, 5, 6] They have reported significant improvement in the majority of the patients treated with L-Dopa. Our series of 20 patients were evaluated without the advantages of a double blind approach, nonetheless the observed improvements from L-Dopa therapy were so obvious that reasonable estimates of improvement have been possible from serial clinical observations, motion pictures, and voice recordings.

The ability of the patient to walk proved to be a rather clear end point for following the progress of drug therapy in the non-ambulatory group. Only one of three patients completely restricted to a chair and/or bed recovered sufficiently to leave these confines and that individual never did attain an independent ability to walk.

Four other patients who were on the verge of wheel chair or bed confinement regained the ability to walk. Three managed this without assistance—some approaching a nearly normal gait. One still needed assistance because of impaired balance.

Two patients who had required considerable help in walking regained this ability with little or no concern for falling.

The 11 other ambulatory patients showed improvements of variable and less spectacular degree but in general moved faster with more confidence and managed turns with much greater ease.

Eight patients showed substantial improvement. Rigidity, bradykinesia, and balance improved most notably; then speech became more articulate and louder; tremor improved more slowly and maximal improvement might require 9 months or more. One patient who made spectacular improvement within two weeks, both in terms of rigidity and tremor, developed a chewing dyskinesia in another two weeks and eventually the medication had to be discontinued.

Another 9 patients displayed at least modest improvement. Two patients, with previous depressive problems, were discontinued from the study because of increasing mental dysfunction. Another, with far advanced disease, was suspended because of failure to respond to therapy. A fourth patient died while receiving the drug but without causative relation to the L-Dopa therapy.

The response to L-Dopa therapy usually was evident by the early part of the second week of the standard program of medication. Improvement continued for a number of months in most patients after a maximal dose was established. Tremor, as noted earlier, was slowest to respond.

Three patients, with a good early response to medication, have reported a decline in the effectiveness of the medication. The increase in symptoms appeared in about six months in two patients and after 10 months in another. Slowness and stiffness were apparent in the morning to one patient who then finished the day with good function. These changes have been managed by rearrangement of the total dose, i.e., giving the medication at different times and in different amounts.

Fifteen of the patients were treated with L-Dopa alone while five continued to take other anti-Parkinsonian medication. When tremor was prominent, the use of the older preparations (artane, cogentin, kemadrin, phenoxene, or benadryl) was continued with L-Dopa, although in reduced amounts.

UNTOWARD EFFECTS AND COMPLICATIONS OF THERAPY

L-Dopa must be administered with a watchful eye for a variety of disabling side effects may appear and require discontinuation of the drug. Such untoward effects can usually be reversed by reducing the dose or discontinuing the drug.

GASTROINTESTINAL EFFECTS

Nausea perhaps due to gastric irritation is a fairly frequent complaint. Patients with peptic ulcer must be watched very carefully. Three patients had significant trouble with nausea and four others experienced mild nausea. Anorexia was common early in therapy.

CARDIOVASCULAR EFFECTS

L-Dopa is a chemical precursor of epinephrine and norepinephrine as well as dopamine. One concern of the early users of this drug was the effect it might have on the cardiovascular system. Fortunately this has not been a serious problem.

Rare instances of ventricular tachycardia,

ventricular fibrillation, and atrio-ventricular conduction defects have been noted. One patient developed rather frequent premature atrial contractions that responded well to a reduction of 0.5 gm. of the daily 4 gm. dose of L-Dopa. Another patient with ECG evidence of an old anterior myocardial infarction showed a transient episode of premature ventricular contractions with spontaneous remission. We did not give L-Dopa therapy to patients with a history of myocardial infarction who had residual atrial, nodal or ventricular arrhythmia.

Two patients developed transient episodes of orthostatic hypotension (30 mm. of mercury difference between supine and erect posture plus concomitant dizziness or syncope). Therapy included instructing the patient to rise slowly and to stand for a few seconds before walking. Also advised was the use of elastic stockings, one or two grams of oral salt daily, and in some a reduction of L-Dopa dosage was tried. The mechanism of this phenomenon is not known.

One patient who had been moderately hypertensive was able to discontinue the use of chlorthiazide some six months after beginning L-Dopa therapy. This tendency for reduction in arterial blood pressure may not, however, persist.

ABNORMAL MOTOR MANIFESTATIONS

Involuntary movements of a wide variety have been described with the administration of L-Dopa. These include chewing, grimacing, blinking, trismus, licking, and torticollis. The head and neck are frequently involved. Choreiform, myoclonic and other involuntary movements may involve the trunk and extremities. The resting tremor of Parkinsonism has been frequently seen to increase during the early weeks of L-Dopa therapy but then to diminish as treatment continues. Most abnormal movements have appeared late in the course of therapy after the maximal dose has been established and maintained for a time. Reduction of dosage will usually alleviate the abnormality but will often lessen the effectiveness of treatment.

One patient in our study was unable to continue using L-Dopa because of the development of distressing episodes of involuntary chewing and grimacing. Some of these episodes were associated with grunting hyperventilation which created an alarming scene that would then remit within a half hour or so. This patient had shown dramatic remission in both tremor and rigidity in two weeks and developed the adverse reaction in the third week. Reduction of L-Dopa to 0.75 gm./day did not alleviate the chewing dyskinesia. Perhaps discontinuation of L-Dopa for a period of several months and then restarting it on a schedule of 125 mg./day with similar increments at 3-day intervals to a lesser total dose of medication (2 gm. or less) might be worth a trial in such patients.

PSYCHIATRIC SIDE EFFECTS

A variety of psychiatric side effects have been noted and include such changes as depression, confusion, anxiety states, delusions, nightmares, euphoria, agitation, anti-social behavior, lethargy, and suicidal tendencies. Such problems may arise in patients without pre-existing mental symptoms. It has been said that these effects do not relate to dose, age, sex or duration of treatment.

Three patients developed increasing confusion, restlessness, and disorientation and medication was discontinued. All three had previously been subject to paranoid or depressive problems but these symptoms clearly worsened during drug therapy. All three had experienced previous difficulty with memory, judgment, and reasoning. Two had previous hallucinatory states and these were aggravated by L-Dopa.

Depressive symptoms appeared in two other patients but these remained mild and responded to frequent supportive interviews. The depression of one patient improved nicely as the effectiveness of L-Dopa therapy became apparent in ameliorating his Parkinsonism.

A considerable number of our patients reported a pre-existing subjective decrement in memory and thinking (about 10 patients). These complaints were not assessed in detail, but no evident change in these symptoms took place during treatment.

An aphrodisiac effect has been attributed to L-Dopa therapy. This was not apparent in our patients.

Finally, the use of a drug which may effectively relieve a patient of incapacitating physical disability will inevitably disrupt dependency relationships within a family. This change may pose no small problem. There is a report of a patient who deliberately and surreptitiously did not take medication to avoid losing long standing emotional support and physical care.

OVERDOSAGE

Overdosage of L-Dopa may produce hypotension, nausea, vomiting, psychic symptoms and various involuntary movement abnormalities. Gastric lavage should be performed in the acute situation along with general supportive measures. Electrocardiographic monitoring should be done to watch for the development of possible arrhythmias.

L-DOPA AND GENERAL ANESTHESIA

One patient required two prostatic operations while under L-Dopa therapy. Both procedures were performed with spinal anesthesia without any adverse reactions. L-Dopa was discontinued on the day prior to surgery and rapidly increased to the standard maintenance dose in a few days following surgery. Local or regional anesthesia is recommended but we are unaware of any adverse reactions to general anesthesia.

No significant laboratory abnormalities have consistently appeared. Patients have been followed routinely with complete blood counts, blood urea nitrogen, and SGOT values.

This summary of potential side effects, while not exhaustive, has stressed those most commonly encountered. In general the complications are well managed by reductions in dosage or discontinuation of the drug.

SUMMARY

L-Dopa has proven to be a most effective drug for many Parkinsonian patients. It appears to work best in younger individuals who have rigidity as the most prominent presenting problem and who do not have long standing disease.

There may still be merit in using the standard anticholingergic-antihistaminic drugs for early Parkinson's Disease. A switch to L-Dopa therapy could then be made as the patient's disability increases.

Patients with long standing and far advanced diseases have not responded impressively in our experience. Patients with cardiac arrhythmias, organic brain syndromes, or significant psychiatric problems must be watched very carefully if they are given L-Dopa. All patients must be observed carefully for potential side effects.

Still the effect of L-Dopa has been most impressive in the majority of our patients and sometimes dramatically so. The availability of this drug for the treatment of a relentlessly progressive and disabling neurologic disorder is a very real advance in the chemotherapy of disease.

* * *

The authors wish to express their appreciation to Hoffmann-La Roche Inc., Nutley, New Jersey, the Neurosensory Center and the Joseph Sirota family who have generously supported the clinical and metabolic investigations carried on in this study. The Neurosensory Center, College of Medicine, The University of Iowa, is supported by Program-Project Grant No. NS03354 of the National Institute of Neurological Diseases and Stroke, Bethesda, Maryland.

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Workshop on Parkinson's Disease

A Workshop on Parkinson's Disease is scheduled November 20 at The University of Iowa. The workshop will be of particular interest to the general practitioner and internist who uses L-Dopa or other new methods of treatment in caring for patients with Parkinson's Disease. The emphasis will be on the day-to-day office management of this problem.

The workshop will begin at 10:30 a.m. in the Department of Neurology. Sponsors are the Department and the Iowa Regional Medical Program. There is no registration fee.

Workshop topics include diagnosis and physical findings, pathology and physiology of the basal ganglia and treatment.

Congenital Nephrotic Syndrome: Case With Electron Microscopic and Family Studies

BONG SIK HAN, M.D., and
MARION E. ALBERTS, M.D.
Des Moines

THE CONGENITAL NEPHROTIC SYNDROME of the neonate was reported in 1954 by Eiben *et al.*[1] This was a documented case in a neonatal premature infant. Subsequent to Eiben's report, a large series of cases of the nephrotic syndrome have been reported, all of them characterized by the onset of disease before 1 year of age. In spite of the need for study of cases of the nephrotic syndrome with a familial tendency, only a few have been reported. The report of Hansen *et al.*[2] in 1961 represented familial disease in two siblings. Our case is that of a neonate with congenital nephrosis who had two deceased siblings with similar disease.

CASE PRESENTATION

History and Physical Examination. The patient, a white male, was delivered at 37 weeks' gestation. Low forceps extraction was necessary because of persistent left occipital posterior position. Birth measurements were: 7 lb., 2½ oz.; length, 19½ in.; head circumference, 13½ in.; and chest circumference, 13 in. At five minutes after delivery, the Apgar score was 1. He had flaccid muscle tone, cyanosis, no reflex responses, and a slow heart rate. Further examination demonstrated generalized edema, severe respiratory distress, and meconium-stained vernix caseosa. Decreased but coarse breath sounds were heard over both lung fields. The heart sounds were normal. During the 44 hours of life, a total of 44 cc. of urine was voided. The infant received oxygen, but no treatment was given other than controlled environment in an incubator. He died on the second day.

FAMILY HISTORY

This infant was the seventh child delivered by his mother. Three children are living and well. Two were afflicted with congenital nephrosis, and one infant was stillborn. (See Table I, which summarizes all the children.) The mother and father presented no evidence of renal disease, nor do any of their relatives. The mother's prenatal course was normal; she demonstrated no abnormalities of her urine.

LABORATORY FINDINGS

The urine was amber and cloudy, with a specific gravity of 1.014. The reaction was slightly acid. It was 4+ for albumin, negative for glucose, negative for acetone, positive for bilirubin, and positive for occult blood. There were 300-400 rbc's/hpf, 4-8 wbc's/hpf; 3-6 hyaline granular casts, 4-8 transitional epithelial cells/hpf, and rare fat bodies. A CBC revealed: hemoglobin, 16.6 mg. per cent, hematocrit, 50 vol. per cent, RBC's 4.57 million/cu. mm., WBC's, 17,900/cu. mm., and the following percentages of WBC's—6 per cent bands, 60 per cent segs, 28 per cent lymphs, and 6 per cent monos. The RBC's showed polychromatophilia and a macrocytic tendency. There were 143 nucleated RBC's per 100 WBC's. The BUN was 12 mg. per cent. Serum electrophoresis revealed 3.1 gm. per cent of total protein, with 43 per cent albumin, 7.5 per cent alpha-1 globulin, 21.5 per cent alpha-2 globulin, 23.6 per cent beta glob-

Dr. Han has completed a pathology residency at Mercy Hospital in Des Moines and is beginning his practice in Mason City. Dr. Alberts is in the private practice of pediatrics in Des Moines.

	1	2	3	4	5	6	7
Birth date	Dec./55	Oct./57	Mar./59	Aug./62	May/65	Mar./67	June/68
Sex	M	F	M	F	F	M	M
Birth weight	6 lb. 6 oz.	5 lb. 9 oz.	5 lb. 11 oz.	6 lb. 9 oz.	8 lb.	9 lb. 9 oz.	7 lb.
Status	Normal; alive & well	Normal; alive & well	Died at 7 months	Died at 6 weeks	Stillborn	Normal; alive & well	Died at 2 days
Clinical findings	Healthy	Healthy	Swollen feet; Periorbital edema; congestive heart failure	Edema; ascites; resp. distress	No external abnormalities	Healthy	Generalized pitting edema; ascites & hydrothorax; resp. distress
Autopsy findings	Living & well	Living & well	Congenital nephrosis; malnutrition; pneumonia	Congenital nephrosis; congestion of viscera	Hydrothorax; hemoperitoneum	Living & well	Congenital nephrosis; ascites & hydrothorax; generalized edema; left renal vein thrombosis with infarction
Urine	Normal	Normal	4+ albumin; 100--200 RBC; 5-10 WBC	4+ albumin; 75-100 RBC; 4-8 WBC	Notavailable	Normal	4+ albumin; 300-400 RBC; 4-8 WBC
Serum albumin	5.4 gm.%	5.3 mg.%	1.1 gm.%	1.0 gm.%	Not done	Normal	2.8 gm.%
Serum globulin	1.7 gm.%	2.2 gm.%	2.2 gm.%	2.8 gm.%	Not done	Normal	0.3 gm.%
Total lipid	590 mgm.%	670 mgm.%	1060 mgm.%	888 mgm.%	Not done	720 gm.%	3100 mg.%

TABLE I—A tabular summary of all seven children.

ulin, and 4.3 per cent gamma globulin. The electrophoretic pattern was considered consistent with the nephrotic syndrome.

AUTOPSY FINDINGS

Postmortem examination of the infant revealed severe generalized pitting edema. Bilateral pleural accumulations of fluid (100 cc. in each thoracic cavity) and ascites (140 cc.) were present. The weight of the kidneys together was 47 gm. The left renal vein contained a thrombus and was associated with a large area of hemorrhagic infarction in the left kidney. Multiple microscopic sections of the right kidney revealed tubular degeneration. These were characterized by markedly swollen proximal tubular cells with areas of cytoplasmic granularity and cytoplasmic vacuolation. The tubular lumina contained eosinophilic granular protein debris similar to the degenerating cytoplasm of the tubular cells. The vacuoles stained for fat with the Oil Red O stain. The distal tubules contained similar proteinaceous granular material but otherwise appeared intact. The glomeruli throughout were congested. Their immaturity was evident by the persistence of the peripheral arrangement of epithelial nuclei. The capillaries were markedly congested with erythrocytes. The basement membrane appeared normal in thickness generally; however, focally, it appeared questionably thickened. The blood vessels were normal. PAS stains revealed similar findings.

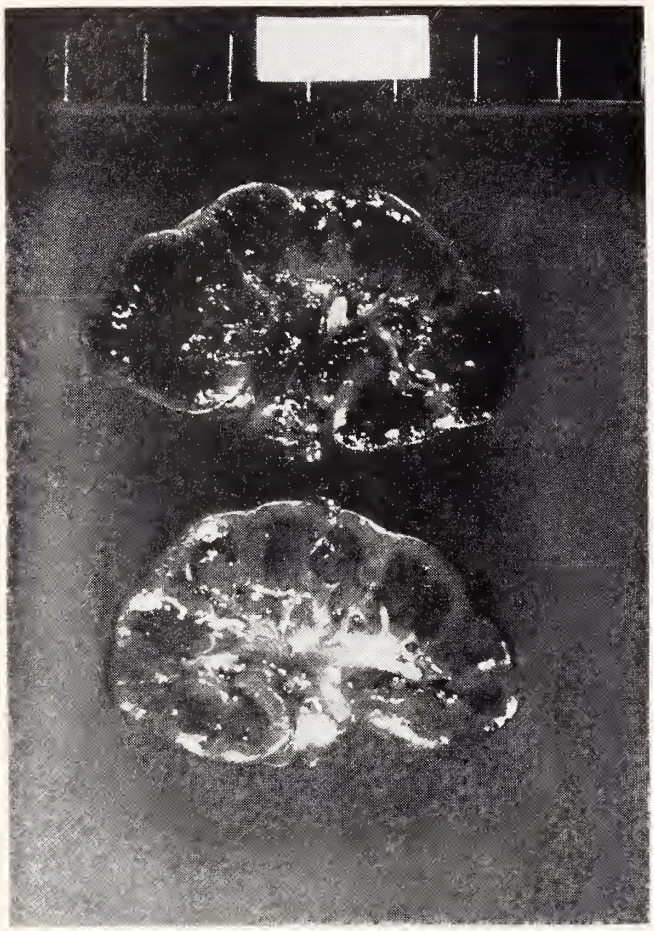


Figure 1. Sections of kidneys show parenchymal hemorrhage in the left kidney due to left renal vein thrombosis.

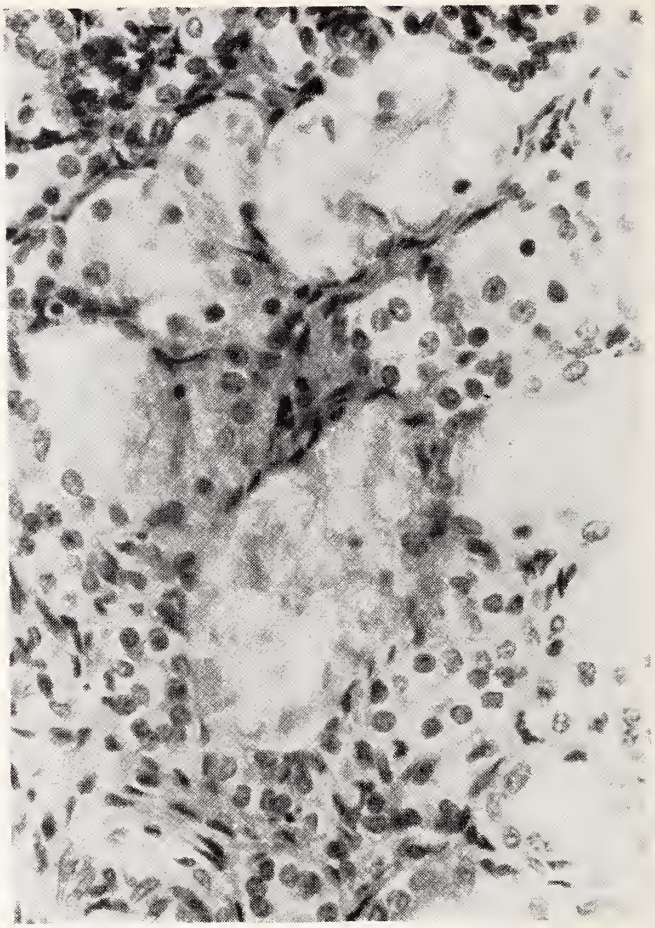


Figure 2. Histologic sections of kidney show extensive tubular degeneration. The cytoplasm of degenerated tubular epithelial cells contains many fine granules.

These same changes were also noted in the left kidney. Additionally, the thrombus in the renal vein was associated with marked congestion and erythrocyte extravasation throughout the parenchyma of the corticomedullary zone of the left kidney. Sections of both kidneys were studied by electron microscopy. The findings were those of congenital lipoid nephrosis. The glomerular epithelial cells showed large sheets of cytoplasm which covered the outer surface of the basement membrane. These represented fused epithelial cell foot processes. No normally formed foot processes could be identified. The basement membrane was thin as expected in an infant. There were no lesions suggestive of an inflammatory process and no evidence of protein deposition on the basement membrane. Bowman's capsule was not thickened. The tubular pattern appeared normal. Lung sections revealed extensive areas of intra-alveolar hemorrhage consistent with an anoxic etiology.

The nephrotic syndrome, when it occurs before 1 year of age with a familial tendency, is very rare. It is referred to usually as "familial congenital nephrosis." Prader and Goettsch[3] reported its occurrence in twins. Werner and Franconi[4, 5] studied the familial tendency. Vernier *et al.*[6] reported 4 cases in a single family. Our study cites 3 cases in a family of 7 siblings. All died within 7 months of age. This series of events would indeed indicate a poor prognosis. This finding is in agreement with that of Friderich,[7] who described a poorer prognosis with familial congenital nephrosis than with sporadic nonfamilial nephrosis. Worthem *et al.*,[8] in 1959, also described a poor prognosis with infantile nephrosis when compared to nephrosis in the older child.

The exact etiology of congenital nephrosis is still obscure. The currently in vogue theories include the autoimmune theory and the inborn metabolic error theory.

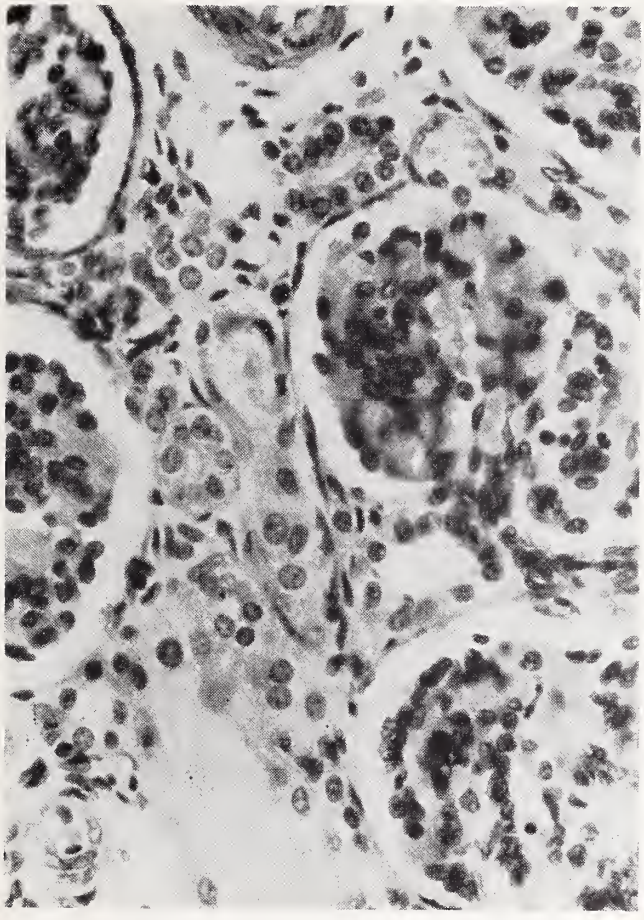


Figure 3. Glomerular hemorrhage with thickened glomerular capillary basement membranes is evident. (450X) (H & E).

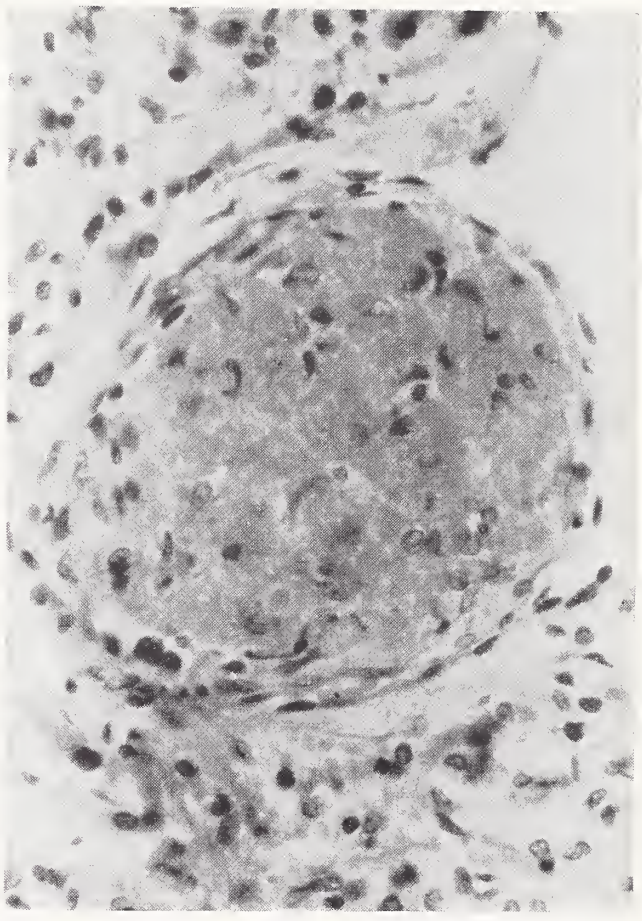


Figure 4. Left renal vein shows organized thrombus. (100X) (H & E).

Although Grusky and Toronto[9] suggested that autoimmunity may be unimportant because of the immunologic impairment of the fetal antibody-producing mechanism, Worthem *et al.* pointed out that antibodies may be produced by the mother. In such a case, an antigen with a hapten common to the fetal kidney may induce antibody formation within the mother, and subsequent reaction between antibody and fetal kidney may then produce disease. In these cases disease might be expected in the mother. This is found infrequently, although Worthem in his own cases reported toxemia with each pregnancy.

Giles *et al.*[10] suggested there may be an inborn error of metabolism responsible for infantile nephrosis. Although the exact inborn error has not been defined, the presence of crystals in alcohol-fixed liver, spleen, bone marrow, and kidneys has suggested this as a possibility. Other authors have demonstrated the crystals to be a product of the alcohol method of fixation.

The findings, as reported in cases of congenital nephrosis, have been similar. Clinically, the syndromes are characterized by edema, albuminuria, hypoalbuminemia, hyperlipemia, and an elevation of the erythrocyte sedimentation rate. The serum proteins by electrophoresis show a pattern which is characteristic. There is a marked decrease in albumin and gamma globulin and an increase in the alpha and beta globulins. Low serum mucoproteins are also present.

Histologically, the lesion of congenital lipoid nephrosis consists of both glomerular and tubular alterations. The glomerular basement membrane is thickened and shows splitting. There is fibrinoid deposition. The renal tubules, especially the proximal convoluted ones, show dilatation and hyaline granular degeneration. Lipid droplets are present within the swollen tubular epithelial cells. By electron microscopy other changes are described. They include fusion of the normal foot processes of the glomerular epithelial cells,

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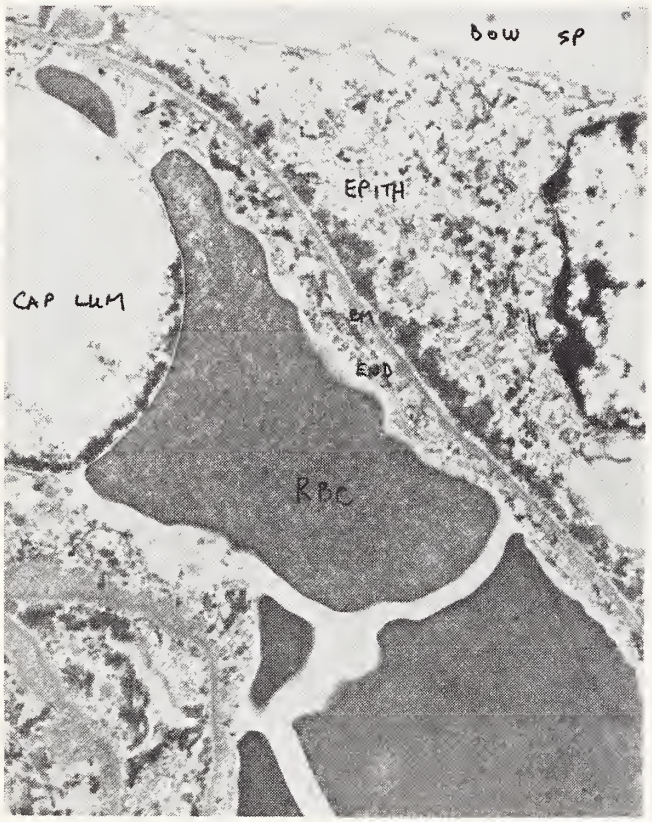


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Figures 5 and 6. Electromicroscopic sections of right kidney show large sheets of glomerular epithelial cytoplasm covering the outer surface of basement membrane with numerous microvilli. No normally formed foot processes can be identified. (16,240X, 23,490X, respectively) KEY: Cap Lum—Capillary Lumen, RBC—Red Blood Cells, END—Endothelium, Epith—Epithelium, BM—Basement membrane, and Bow Sp—Bowman's space.

the presence of increased numbers of vacuoles in the epithelial cell cytoplasm, increased endoplasmic reticulum, prominent basophilic particles and increased Golgi material in the cytoplasm of the epithelial cells. The basement membrane itself is thickened and shows areas of degeneration characterized by clear empty spaces.

To date, no specific therapy for congenital neonatal lipoid nephrosis appears adequate. Attention, however, must be paid to the prevention of infection and the correction of water and electrolyte imbalances. Steroids and hemodialysis have been used.

SUMMARY

This is a case of congenital neonatal nephrosis in a patient who lived approximately 2 days. Two of 6 other siblings had the disease and died as a consequence of it, prior to the age of 7 months. This seems to be an unusual situation which requires more familial studies.

Dr. Benjamin H. Spargo, Professor of Pathology, University of Chicago, did the electron microscopic examination studies of the kidneys.

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Indications for the Use of Anticoagulants in Stroke Syndromes

JOHN R. TAYLOR, M.D., and
MAURICE W. VAN ALLEN, M.D.
Iowa City

Reduction of coagulability of the blood is one of the major therapeutic possibilities in threatened or completed stroke. The indications for the use of the anticoagulant drugs and their potential hazards in certain situations are still the subject of debate. This article is an attempt to guide the physician in the management of his patients by reference to the best and most recent available experience in the use of this modality of treatment. Several agents are now available, and, except in certain circumstances, no effort will be made to compare them. Furthermore, the newer agents, e.g. Malayan pit viper fraction 6 (Arvin) and the thrombolysins, will not be discussed since they remain largely experimental. The physician, in most cases, is advised to use an agent familiar to him, and to enhance that familiarity by frequent reference to current texts and to the pharmacologic literature. Our comments are intended to identify the patient with cerebrovascular disease who might benefit from anticoagulation, and to presume that the drugs likely to be employed are either heparin or one of the coumarin derivatives.

COMPLETED CEREBRAL INFARCTION

As early as 1958, Millikan, *et al.* demonstrated a rather low mortality (8 per cent) due to infarctions in the vertebral-basilar artery distribution when patients with symptoms of ischemia were treated with anticoagulants. However, there were no untreated controls.[1] In a controlled study, McDevitt *et al.*[2] at about the same time found a significantly lower incidence of all thromboembolic episodes in anticoagulated patients, but her studies mixed definite embolism with probable thrombotic disease. These encouraging beginnings, however, were perhaps overly optimistic, for later, two cooperative studies[3, 4] found higher mortalities for treated groups. These differences (15 per cent mortality for the "treat" group vs. 6 per cent for controls in the first study, 23 per 1,000 patient months vs. 15.4 per 1,000 patient months in the second study) were significant. Subsequently, Siekert, Whisnant and Millikan,[5] in a study involving anticoagulants, stated that "patients with completed stroke . . . were not treated by us with anticoagulant drugs," emphasizing their own changing attitude.

More recently, Enger and Boyesen[6] in a very careful study excluding hypertensives, patients over 75, hemorrhagic and embolic strokes, and serious other medical conditions, followed 100 patients, treating 51. They found that there were 10.0 new infarctions per 1,000 observation months in the control group, as opposed to 4.3 per 1,000 months in the treated group, but these figures were not considered statistically significant. During the mean treatment period of 22.8 months, the anticoagulated group experienced a mortality rate of 4.3 per 1,000 observation months (6 deaths) while the placebo group suffered a rate of 5.4 per 1,000 months. All deaths were attributable to cerebrovascular disease. The difference in the figures is insignificant. Since that time, fewer controlled studies are available, and Browne and Poskanzer,[7] in their review of the entire subject, concluded that "our experience indicates that hemorrhagic complications of anticoagulant therapy [in

Dr. Taylor is an instructor and Dr. Van Allen a professor in the Department of Neurology at The U. of I. College of Medicine. Both are participants in the Central Stroke Educational Project of the Iowa Regional Medical Program.

completed thromboses] can only be controlled by complete discontinuance of the therapy." On the other hand, 26 per cent of the survivors of an infarct ultimately have another, and 62 per cent of these succumb.[8] Thus, since only about one-third of these patients have transient ischemic attacks (TIA's) as harbingers of more trouble, there is no doubt some justification for the preventive use of anticoagulants in the healed infarct, presuming that anticoagulants prevent subsequent infarction. However, considering present drug usage, patient selection criteria, and laboratory control methods, anticoagulation therapy in completed infarction is contraindicated early and is of doubtful value for later prophylaxis.

THROMBOSIS-IN-EVOLUTION

Anticoagulants may be of greater aid in other stroke syndromes. Many patients, over a period of hours to several days, display progressive increase in their neurologic deficit, a syndrome sometimes referred to as *stroke-in-evolution.* For simplicity of definition, some have labelled any stroke a *stroke-in-evolution* for the first 72 hours following the onset of symptoms. In their findings on *stroke-in-evolution,* Baker *et al.,* in a cooperative study,[4] found a slightly lower mortality among controls than among anticoagulated patients, but among 35 separate episodes of *progression,* 26 occurred in the control group. This implies strongly that morbidity can be reduced with anticoagulants. Furthermore, Siekert, *et al.*[5] state that both morbidity and mortality are lower in their treated patients than the controls, though their data is not provided. Carter[9] selected 76 patients for a controlled study. Treatment of 38 patients was with intravenous heparin, then phenindione (Danilone) orally. Of the controls, 18 per cent died as opposed to 8 per cent of the treated. Considering quality of survival, 68 per cent of the treated group were either recovered or improved, versus 50 per cent for the controls. These figures were believed to be statistically significant. Interestingly, the deaths (7) in the control group were attributed to pulmonary embolism in 3. Of the 3 deaths in the treated group, 1 was due to a hemorrhagic infarction.

In a more recent paper,[10] and somewhat by inference, TIA patients were randomized and a portion anticoagulated. Four control patients subsequently had an infarction, 2 with mild sequelae, whereas in the 2 treated patients who developed paralysis, neither had residual deficit. In addition, 3 patients who discontinued anticoagulants and had subsequent infarctions were all severely affected. The implication of this data is that patients anticoagulated at the beginning of their episode will have less residual deficit, however, the numbers involved are too small to be significant. Finally, Marshall[11] concluded that therapy will "arrest the progress of a *stroke-in-evolution* in a considerable percentage of cases," but emphasized the necessity of initiating treatment very early. Undoubtedly, further clinical trials are indicated in this condition, but there is ample evidence to assume that heparin *early* in a *stroke-in-evolution* carries little added hazard and substantial potential for benefit, *if* the diagnosis is certain. Regrettably, this last requirement is formidable, since hemorrhages are sometimes stuttering in their onset, and tumors with occasional focal seizures or hemorrhages can be distressingly similar, clinically, to an evolving stroke.

TRANSIENT ISCHEMIC ATTACKS

Transient neurologic deficits attributable to vascular disease and lasting less than 24 hours, with complete recovery, are often referred to as transient ischemic attacks, the term implying that the vascular event is non-hemorrhagic. Such symptoms are well reputed to respond to anticoagulant therapy. While an occasional dissenter can be found,[12] the majority of studies[1-3, 5, 13, 14] indicate that the number of TIA's suffered by the patient are reduced by anticoagulant drugs, almost always given orally. Several writers[5, 10, 14] also believe that anticoagulation prevents infarction.

Another encouraging finding is that of a reduced disability in those treated,[10] though this is merely suggestive. One must, however, consider the natural history of this disorder[15-19] and know that the incidence of subsequent permanent stroke is, on an average, 19.4 per cent (not including Marshall's[16] findings of an extremely low incidence). Additionally, mortality figures are

misleading since few TIA patients ultimately die of cerebral infarction anyway;[19] a majority die of cardiac disease (59 per cent), pneumonia, gastrointestinal disease, and from other causes. Furthermore, the mortality rate through the fourth year of follow-up averages only 4 per cent per year, making comparison on the basis of mortality rather difficult. Hence while there is evidence that anticoagulants prevent subsequent infarction and death, such evidence is moderated by the rather benign natural history of transient attacks. Furthermore, little has been done to exploit, therapeutically, the moderately different natural course of posterior circulation ischemia as opposed to carotid insufficiency.

While certain patients in this group have been found to be candidates for extracranial vascular surgery,[20] others have not, and anticoagulant therapy may be desirable. One must remember that approximately 61 per cent of untreated patients spontaneously cease having their attacks in a year,[16, 18, 19] thus, cessation of therapy may be considered after that period if the patient is asymptomatic. Long-term anticoagulant treatment is not without risk, and associated death rates related to treatment range from 0.003 to 0.760 per patient month.[7]

CEREBRAL EMBOLISM

Cerebral embolism is a complex subject, and we cannot discuss it in a complete manner. Suffice it to say that anticoagulants are useful chiefly in emboli due to blood clots, although atheromatous emboli apparently are also prevented by anticoagulants. In older patients, this latter condition should always be suspected, and a search of the eyegrounds for embolic material is often fruitful. The principal problem concerns the timing of anticoagulant administration. There is some justification for giving the drugs prophylactically as soon as a potential embolic condition is recognized. Thus, anticoagulation preceding cardioversion is an accepted therapeutic program by some.[21] Furthermore, McDevitt *et al.*[2] were able to show fairly conclusively that the incidence of repeated embolic episodes is substantially reduced by continuous anticoagulant administration. Interestingly, they also found that the curve of repeated embolic episodes began to "flatten" only after the fourth or fifth year following the first episode, suggesting the need for long-term therapy.

The greatest problem occurs when one is confronted with a patient who has recently suffered an embolic stroke. Hemorrhagic infarction is high in embolic disease, though by no means invariable. Animal studies[22] have indicated a tendency for hemorrhage if the embolic particle moves and permits re-establishment of flow, or if the blood pressure rises. In humans, an autopsy series[23] demonstrated that in those cases in which the embolus was actually found, 63.6 per cent had confluent hemorrhagic areas in the infarct. In those cases in which the embolic particle could not be found, the incidence of hemorrhage was 80.8 per cent. This difference may be attributed to the pathophysiology of hemorrhagic infarction, in that those emboli that break up and permit a full head of pressure to perfuse the damaged areas are likely to lead to bleeding. The use of anticoagulants in a situation that is more likely than not already hemorrhagic is a course likely to invoke great trepidation. Toole[24] has said that if the lumbar puncture is bloody, anticoagulation might best be postponed. Statistically, however, both Wells[25] and McDevitt[2] had patients who developed embolic infarction while anticoagulated, but they were unable to find a significant difference in morbidity or mortality as compared to similar episodes in the untreated groups. More recently, Browne and Poskanzer[7] concluded that the advantages of the early use of anticoagulants outweighted the risks, particularly when one considers the tendency of embolism to recur soon after the first episode.

There appears, then, to be no firm answer on the appropriate timing of anticoagulants in cerebral embolic disease, but the weight of the evidence favors early use following an event, and prolonged use unless the predisposition is alleviated.

CONCLUSION

1. Anticoagulant therapy is hazardous early in the completed thrombotic stroke, but may be of prophylactic benefit later, though this is far from certain.

2. Thrombotic *stroke-in-evolution,* if the diagnosis is definite, should be treated early with intravenously administered heparin.

3. Transient ischemic attacks may be ameliorated with long-term anticoagulation, and possible future infarctions may be prevented. Further study is needed to establish the latter point. Surgery may be advisable in some of this group.

4. Cerebral embolic events, when the source of the embolus is presumed fragmented thrombus, fibrin thrombus, platelet aggregates or cholesterol, are an indication for early and prolonged anticoagulation.

5. Anticoagulants are hazardous drugs with many well known contraindications. Careful selection of appropriate patients should include close attention to these contraindications.

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Conference on Obstetrics and Gynecology

A Postgraduate Conference on Obstetrics and Gynecology is scheduled for December 9 and 10 at the Iowa Memorial Union at the University of Iowa. The conference is sponsored by the Department of Obstetrics and Gynecology, College of Medicine; the Iowa Obstetrical and Gynecological Society; Division of Maternal and Child Health, State Department of Health, and the Iowa Division, American Cancer Society.

Conference speakers from the University faculty include J. T. Bradbury, Sc.D., J. J. Buchsbaum, M.D., F. K. Chapler, M.D., J. H. Christie, M.D., R. P. Galask, M.D., C. P. Goplerud, M.D., L. R. Hughes, M.D., W. C. Keettel, M.D., R. M. Kretzschmar, M.D., H. B. Latourette, M.D., R. M. Pitkin, M.D., Dianna Van Orden, M.D., C. A. White, M.D., and M. E. Yannone, M.D.

Guest faculty will include Mrs. Minnette Doderer, State Senator, Iowa City; W. E. Edgerton, M.D., Davenport; R. F. Mattingly, M.D., Marquette University, Milwaukee; D. O. Newland, M.D., Des Moines, J. J. Sciarra, M.D., University of Minnesota, Minneapolis, and J. J. Straub, M.D., Dubuque.



Editorials

CAREFUL FOOD HANDLING: A MUST

While it did not originate in Iowa, the recent outbreak of salmonella infection in Sioux City and surrounding area is a dramatic reminder that there can be no relaxation in the regulation, supervision and inspection of food vendors and vendor personnel; this is a must if similar epidemics are to be prevented.

Well over 200 citizens in the Sioux City area were infected, 30 of them had to be hospitalized. Fortunately there were no deaths. The Sioux City Health Director, Thomas E. Carothers, reportedly said the persons who became ill from food poisoning in this epidemic had one common source of infection. They had all eaten at the same restaurant just across the Missouri River, some time between September 8 and 18.

According to press reports, 29 of 120 employees of the eating establishment where the many guests presumably acquired the infection had positive fecal cultures of Group D salmonella. It is hardly conceivable these 29 employees acquired the infection simultaneously. It is equally improbable that the infected food handlers were without symptoms which necessitated some absence from duty. The alert personnel supervisor would note a sick employee and would make sure he or she did not return to duty until certification by a physician that no communicable disease was present.

It appears there was gross contamination of food by a food handler who was either a carrier or had an acute salmonella infection. The involved food must have stood at room temperature for a considerable time to serve as a culture medium for the organism. The circumstances seemed to fit together like a jigsaw puzzle to make such an epidemic possible.

The Sioux City outbreak raises the question, how well are the citizens of Iowa protected from illnesses resulting from faulty sanitation and improper practices in the restaurants and food vending units within its borders?

In common with several other states in the Midwest, the State Department of Agriculture has the responsibility for assuring that food vendors comply with the laws and rules relating to the operation of restaurants and hotels, including sanitation laws. This responsibility was invested in the Department of Agriculture back in the twenties when the greatest food hazards were dairy products, meat and poultry. The Department also is responsible for the enforcement of the Pure Food Laws and the Iowa Meat and Poultry Inspection Act and its Dairy Division checks farms and dairies on the production and distribution of Grade A Milk, in accordance with the regulations of the U. S. Public Health Service.

The Agriculture Department operates its own laboratory independent of the State Hygienic Laboratory in Iowa City. It has a staff of 13 inspectors or sanitarians who have the responsibility for inspecting the many restaurants and various types of food vendors throughout the state.

In a number of the state's larger cities the responsibility for sanitation and proper operation of establishments serving food is invested in the local Department of Health. This may be the City Department of Health or a combined City and County Health Department. The local health organization has

Editorials continued...

a chief of environmental sanitation, supervisory sanitarians and individual sanitarians who make inspections sufficiently often to assure the proper operation of each restaurant.

There are some 8,000 food vendors serving the public in Iowa. Even though local health departments have the responsibility for the proper operation of the restaurants in the larger communities, there remain a very large number in the smaller cities and towns which must be inspected by the 13 sanitarians of the Food Products Control Division of the Iowa Department of Agriculture. It is required that each food-serving establishment be inspected at least annually.

Although much more frequent checking of the 8,000 cafes and restaurants throughout the state might seem wise, this would require a huge staff and great expense. Operators of public eating places and personnel supervisors, and inspecting sanitarians must make special efforts to instruct employees as to the rules and regulations and the proper operations to assure the safety of the public.

An effort has been made by the Department of Agriculture to persuade the General Assembly to incorporate the Food Sanitation Manual of the U. S. Public Health Service into the Code of Iowa. This manual is in effect in 22 states and it would be in the interest of the health and welfare of our citizens to adopt it in Iowa. As a matter of fact many provisions in this manual have already been incorporated into those Department of Agriculture rules and regulations which pertain to food. In general the provisions of the Federal Manual are somewhat more strict; they require pre-employment physical examinations and such further exams during employment as circumstances may require. There has been some opposition to the adoption of the U. S. Public Health Manual because of fear that more strict rules and regulations might be prohibitive for the small operator in rural areas.

It would appear that the public, the medical profession, and the legislature should assume a greater interest in and concern for the proper operation of restaurants and the laws which relate to sanitation. The public is entitled to safe water, safe food, and safe disposal of waste and sewage. It is only through the cooperative effort of the various agencies at the different levels of responsibility that these goals can be reached and maintained.

Apropos the question of sanitation and the safety of food and drink, a "Letter to the Editor" in the September 19 issue of THE LANCET should make us all grateful we live in Iowa where a conscientious effort is being made to prevent the spread of disease. This letter stated that:

". . . It was calculated that there were 120,000 cases and 13,000 deaths from Shiga dysentery in Guatemala between September, 1968 and August, 1969. There have been multiple importations into the United States, including 2 deaths from disease acquired in Nicaragua . . . a half century has passed since the world has seen Shiga epidemic dysentery in such a scale . . . we are seeing in Central America the results of a virulent organism into a non-immune susceptible population with widespread unfavorable sanitary conditions."

The letter was signed by four research workers who are working at three different research centers in this country to develop an oral vaccine for the control of Shiga dysentery.


Dollars Today—
—Doctors Tomorrow
American Medical Association
Education and Research Foundation
535 North Dearborn Street, Chicago 10, Illinois
AMA-ERF

POSSIBLE AGENT IN THE TRANSMISSION OF CROHN'S DISEASE AND ITS SIMILARITY TO SARCOIDOSIS

Search for an etiology of Crohn's disease (regional ileocolitis) has so far been unfruitful. Two workers in England, D. N. Mitchell and R. J. W. Rees, have developed a new and intriguing method of investigation.* It has been known that positive Kveim tests were found in a proportion of mice given homogenates from Crohn's disease tissue and all were associated with granulomas in the foot pads. All Kveim tests were negative in mice given non-Crohn homogenates. Crohn's disease and sarcoidosis are the only diseases associated with a substantial proportion of positive Kveim tests in human disease.

These workers have been studying the problem of transmission of these two diseases to mice for several years. Their method has been to take mice rendered immunologically deficient by removing their thymus gland and by giving them body x-ray therapy (900 R) at an early age. As a control they inject the foot pad of a mouse with material from normal lymph nodes or tissues containing Crohn's tissue or sarcoid homogenates, and examine the foot pads early (26 to 46 days) and late (169 to 500 days). They have chosen the late period because of the delay in disease processes in mouse foot pads in leprosy. They have also injected the material into the mouse's abdomen for proof of sterility. Care was taken to avoid possible inclusion of glass, cotton, wool or other foreign bodies. The early histology of a substantial proportion of the foot pads of mice innoculated with Crohn's disease homogenates showed characteristic granulomas clearly distinguishable from the highly cellular inflammatory response seen after the same interval in the foot pads of a small proportion of mice given non-Crohn's lymph node homogenates. Moreover, the late histological appearances of foot pads innoculated with Crohn's tissue homogenates showed persistence of epithelioid in giant cell granulomas. In sharp contrast the highly cellular inflammatory lesions seen in the early histology of some of the foot pads innoculated with non-Crohn's lymph node homogenates were no longer apparent in the same or contra-lateral foot pads. Positive Kveim tests were confined to the ears of the mice given Crohn's tissue homogenates and were all associated with epithelioid giant cell granulomata of the foot pads. Moreover, granulomas were not present in any of the Kveim test sites in mice not given Crohn's lymph nodes homogenates and Kveim tests in all of these mice were microscopically negative.

The authors believe they have discovered a transmissible agent for mice from the human sarcoid and Crohn's disease tissue, and that the disease evolves over a period of six months to two years. It is of interest that lesions associated with the granulomatous stage of human leprosy have recently been seen in the foot pads of normal mice only after prolonged intervals of up to two years after innoculation. Efforts to determine the nature of this agent by passage are especially relevant since the transmissibility of a living agent from sarcoid and Crohn's disease suggests that each might be caused by a common infectious organism.

It is true the authors have not discovered the organism which causes these diseases, but they have at least given us a new method to use in studying the etiology of these diseases. It should also be mentioned that lesions are not found in all mice injected with the material, but only in about a third. However, they are not present in any of the normal controls. It is also of interest that granulomatous changes were seen in the bowel walls of the terminal ileum in two of the 10 normal mice which had been innoculated with Crohn's tissue homogenates and subsequently killed. One of these mice also showed miliary granulomas in the liver. Both of the mice showed focal granulomas in the foot pad and were Kveim positive. It is to be hoped that these promising experiments will be continued and that some day in the near future we may have discovered the etiology of these two enigmatic diseases.

—D. A. GLOMSET, M.D.

* Mitchell, D. N., and Rees, R. J.: A Transmissible Agent From Sarcoid Tissue. LANCET, 2:81-84, 1969.
Mitchell, D. N., and Rees, R. J.: Agent Transmissible From Crohn's Disease Tissue. LANCET, 2:168-171, 1970.

Editorials continued...

IMMUNIZATION LEVELS NEED CONSTANT ATTENTION

The outbreak of diphtheria in San Antonio should prompt every community in the land to assess the immunization level among its children and make certain that a false sense of security does not exist. The inquiry should not only include primary immunization in infancy but assurance as well that booster injections at recommended intervals have been carried out.

The preliminary report from San Antonio listed 66 cases of diphtheria in the following age brackets:

Age	Number	Per Cent
Less than one	2	3.0
1 to 4	10	15.2
5 to 9	27	40.9
10 to 14	21	31.8
15 to 19	2	3.0
20 & above	4	6.1

In this group of 66 cases, 71 per cent had received no primary immunization. At latest report the number of cases totaled 99, among whom there were 2 deaths.

Iowa is one of 11 states which does not require a certificate of immunization upon admission of a child to school. This issue has been debated pro and con, and it is the contention of many that this recognized health protection measure should be required by law. The matter certainly deserves serious and ongoing study by physicians, the public and the legislature. The Society's House of Delegates has considered the subject in several recent years.

The Immunization Division of the Iowa State Department of Health recognizes there are deficiencies in the immunization program for children. Many community programs are excellent, most of the children are given primary immunizations and recall booster inoculations are given at recommended intervals. However, there are areas in which no special effort is made to provide immunization and the precise status of immunization is unknown.

The Immunization Division has made a practice of inquiring about primary immunization 18 months after birth registration. In 1968, some 40,000 inquiries were sent out, and of those returned, 58 per cent reported that 3 doses of DTP had been completed. The Department estimates from 20 to 30 per cent received 2 doses but failed to receive the required third injection.

According to reports, poliomyelitis immunization has decreased nationally, thus each annual crop of susceptible infants and children are not being adequately protected. It is unthinkable that children should die or be crippled for life from a disease which can be prevented by an oral vaccine. Can the memories of the impact of an epidemic of poliomyelitis on individuals and the community ever be forgotten? Surely this question demands careful scrutiny in every community, in every physician's office, and in every family.

The 1970 Report of the Committee on Infectious Diseases of the American Academy of Pediatrics recommends the following schedule of active immunization and tuberculin testing of normal infants and children:

Age	Immunization
2 months	DTP, Trivalent Oral Polio Vaccine
3 months	DTP
4 months	DTP, Trivalent Oral Polio Vaccine
6 months	Trivalent Oral Polio Vaccine
12 months	Tuberculin test, Live measles vaccine
15 to 18 months	DTP, Trivalent Oral Polio Vaccine, Smallpox vaccine
4 to 6 years	DTP, Trivalent Oral Polio Vaccine, Smallpox vaccine
12 to 14 years	Td, Smallpox vaccine, Mumps vaccine
Thereafter	Td every 10 years, Smallpox vaccine every 3 to 10 years.

Td is combined tetanus-diphtheria toxoid, adult type. Live rubella vaccine is recommended between the ages of one year and puberty. It should not be given to pregnant women.

The need for Smallpox vaccination is now being questioned, but until it is completely eliminated throughout the world, protection against this highly contagious disease would appear to be a wise precautionary measure.

The frequency and the speed of travel to all corners of the earth make the spread of Smallpox a potential hazard which should not be ignored.

Because of the uncertainty concerning the status of immunization in many areas of the state it would appear that each county medical society should assume the responsibility for a campaign to make certain all children are adequately protected. This can be accomplished in the physicians' offices or in a community clinic. The cooperation of the schools, the local news media and various lay organizations would assure the success of such a campaign. The Immunization Division of the State Department of Health will provide necessary immunization materials and if necessary, personnel to assist in the program.

A HOOSIER SUCCESS

According to press reports, the Wadena Rock Festival was a disgraceful affair which benefited no one but the promoters. By contrast, the August issue of the JOURNAL OF THE INDIANA STATE MEDICAL SOCIETY tells of the success "far beyond anyone's anticipation" of a *Hoosier Teen Health Happening* which was presented in Indianapolis this April under the auspices of the State Medical Society.

The *Happening* lasted a-day-and-a-half and was attended by over 3,000 Indiana high school students from 251 private, public and parochial schools. It was held at the Indiana State Fairgrounds.

The conference program dealt with some of the serious problems confronting young people today—drugs and drug abuse, alcoholism, mental health, traffic safety and smoking. The format consisted of 30-minute presentations by the conference speakers, followed by 30-minute question and answer periods. Among topics presented were *The Speed Scene*—the use and abuse of drugs; *How to Kick the Habit,* told by teenagers who had successfully done so; a discussion of *Teenage Drinking; Hawk, Dove or Chicken*—highway safety and youthful drivers; *Tobacco and Its Effects; Why Students Crack Up*—a discussion of student mental health; and *Sex and the Teenager.*

A survey among those who attended the conference indicated high enthusiasm for the subjects and the speakers. The intelligent and frank questions from the audience contributed generously to the interest and the spirit of the conference.

A local television station broadcast the program live and in color, and the reaction as measured through the station's rating system was the highest ever for a program of this nature. The president of the Indiana State Medical Society said because the conference was so enthusiastically received by the youthful audience, the teachers and the chaperones, the Society is already making plans for another similar program. In formulating the conference it was felt it would be a good public relations effort by the Society, and the results indicated it was an outstanding accomplishment.

As a follow-up to the program, the Society is loaning tape recordings and 16 mm. films of each presentation to the schools. In addition the tapes and films have been made available to local and educational television outlets.

The Indiana Society members are to be commended for their imagination and efforts in presenting this program. Groups of young people returning to some 250 different schools throughout the state cannot help but influence many thousands of their peers and aid them in the difficult process of growing up in this troubled era.

Other organizations might well emulate the example of the Indiana State Medical Society and offer programs of a similar nature. The two annual statewide conferences in Iowa (the second was in Des Moines October 7) on the problem of drug abuse are comparable programs which should result in a better understanding of this serious problem. These conferences have been under the auspices of The Iowa Health Council. Community programs of a less pretentious nature could have a salutary result for both teenagers and parents.

Editorials continued...

CERVICAL LYMPH NODE BIOPSIES

A review* of 163 biopsies of cervical lymph nodes over a 4½ year period at Butterworth Hospital, Grand Rapids, Michigan, by Doctors Lee and Helmus, is of unusual interest and it teaches some valuable lessons.

Excluded from the study were clinically unpalpable prescalene nodes excised in the evaluation of patients with carcinoma of the lung and glands from radical neck dissection. On the basis of microscopic examination, specimens were classified into 1 of 6 categories as follows:

		Per Cent
Normal node	11	6.7
Hyperplastic lymph node	29	17.8
Inflammatory reaction	40	24.5
Hodgkins disease	18	11.0
Other lymphomas	17	10.4
Metastatic carcinoma	48	29.4

In patients over 40 years of age, 41 of 89 (46 per cent) biopsy specimens revealed metastatic carcinoma.

In the 48 cases of metastatic carcinoma involving the cervical glands, the primary source of the disease was in 15 different anatomical sites. As would be expected, the largest number originated in the lung; 7 were from the pharynx and larynx; 4 each from the thyroid and breast; and smaller numbers from the cervix, ovary, trachea, pancreas, and even 1 each from the colon and prostate.

The primary site was known before cervical biopsy in 39 of the 48 cases with metastatic carcinoma. In the 9 instances in which biopsy was done without prior knowledge of the site of the primary tumor, the origin of the disease was never identified in 3 of them. In the other 6 cases, which involved 5 patients, a primary carcinoma of the pharynx or larynx was later identified. Brief case records of these 6 patients are presented.

In a discussion of their report the authors emphasize that biopsy of a palpable cervical node may seem to be an innocuous procedure, however when the lymph node is involved from a regionally metastatic carcinoma from the head or neck, biopsy violates a basic rule of *en bloc* technique of excision, and contaminates the surrounding healthy tissues. To avoid this, patients presenting with a palpable cervical node should have a thorough examination of the head and neck before considering biopsy of the lymph gland.

In their conclusion the authors state that in the series of cervical lymph node biopsies the procedure was contraindicated in 6 of the 163 cases (3.7 per cent), and that it was probably detrimental to the patient. These patients had a carcinoma of the pharynx or larynx not diagnosed prior to cervical lymph node biopsy because it was not searched for. It is urged that adult patients presenting with palpable cervical lymph nodes be considered to have a carcinoma of the head and neck until the diagnosis is excluded.

* Lee, J. G., and Helmus, C.: Cervical lymph node biopsy. MICH. MED., 69:581-583, 1970.

Name Dr. Keettel President-Elect

Dr. William C. Keettel, professor and head of obstetrics and gynecology at The University of Iowa, has been elected president-elect of the American Association of Obstetricians and Gynecologists. Dr. Keettel now serves as president of the American Association of Professors of Obstetrics and Gynecology.

The membership of the American Association of Obstetricians and Gynecologists consists of Fellows, Life Fellows and Honorary Fellows. The number of Fellows is limited to 150.

The Association's objective is "the cultivation and promotion of knowledge in whatever relates to obstetrics and gynecology."

CREDIT & COLLECTION POLICIES FOR THE MEDICAL OFFICE

LARRY E. LEAVERTON
Des Moines

In physicians' offices today, the matter of collections is often neglected. Even with the high percentage of third party payments many accounts still become delinquent. Why is this?

It is complacency in some instances. Because of increasing volume many offices are not aware of the status of their accounts receivable.

In some cases office personnel are either too busy or they are disorganized. When this happens a low priority is given to efforts on collections.

Another cause for delinquent accounts is misunderstanding on insurance and other third party payments.

Despite the claimed affluence of our country many families are caught in a credit squeeze of installment buying, the high cost of living, labor problems or unemployment. The patient frequently decides the doctor's bill will be paid last.

What are the essentials of a good credit and collection program policy?

In the small medical office the responsibility for collections usually falls on the receptionist-bookkeeper. In group practice one individual can spend almost full time in this area. The person assigned this responsibility should follow a systematic procedure. In all office systems and procedures we hear references to "exceptions," but the bulk of the problems can be fit into an established system. Some persons think the entire task of billing and collecting can be farmed to an outside firm. We feel a well trained responsible person within the office, who is more in tune with the problems, can do a better job.

The first rule is to get full and complete information when the patient first comes into the office. A patient information record completed by the patient and checked by the receptionist provides this information.

Encourage payments or specific arrangements at the time of service—when the patient is in the office.

Make credit arrangements firmly but tactfully. Be businesslike but still understanding and friendly. We see two extremes in the handling of potential delinquencies—from the "don't worry about it" position to the "hard boiled" attitude.

Send regular and timely monthly statements, completely itemized. This should go without saying, but we still see instances where due to a heavy work load or other circumstances, a statement date is missed.

After statements have been sent and ignored, follow-up by mail is necessary. There are differences of opinion among medical collection authorities on personally written collection letters versus forms. We prefer the forms from a practical standpoint because they can be used regularly and systematically. We have seen cases where the person responsible for collections will say she sends, and prefers, personal notes and letters. Investigation often reveals she does this when she "finds time." Collection letters or notices should be flexible enough to take care of unusual circumstances; they should start with courteous reminders and become progressively stronger as necessary.

In addition to regular follow-up by mail, contact by telephone can be effective. When telephoning a delinquent patient, identify yourself, determine the reason why they have not responded to statements and letters and ask for payment.



Emphasize the importance of a good credit rating. In making arrangements be specific as to amounts and dates promised. Remember, this patient has ignored several statements and letters.

When all possible office follow-up has been attempted to no avail, the account should be reviewed with the doctor, then turned over to an ethical collection agency.

A system of keeping track of the follow-up on your delinquent accounts is necessary. This is most easily done by neat notations right on the patient's ledger card. All collection efforts should be within the realm of good public relations. You will want to cooperate with patients who earnestly want to pay their medical bills but are having financial problems.

It would be ideal if all medical bills were paid promptly and cheerfully. The cold facts show that this is not the case. In fairness to patients who do pay promptly a firm policy should be in effect for the delinquents. Good credit and collection policies will keep delinquent accounts at a minimum.

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.


Gone with the wind

American Association of Medical Assistants

State of Iowa, Inc.

Do We Communicate, 1970 Style?

By the time this arrives in your office, our 14th annual AAMA Convention will be history. Ninety-two more medical assistants will have been certified, including Mrs. Phyllis A. Pederson, Lake Mills, Iowa, a member of the Mason City Chapter. Our congratulations to you, Phyllis!

Iowa medical assistants will be able to relax in the knowledge of a job well done. We can look back on new friendships and the educational benefits derived from taking an active part in an inspiring convention. Many will already be looking forward to attending the 1971 national meeting in Georgia. During the next few months, I will cover the highlights of the convention for the benefit of those who were unable to take part.

Recently, I talked with some young people, and I asked them to tell me what they thought about the medical assistant and her handling of their problems in the medical office. One teenage boy said, "Treat us like human beings, we are the patients who are being treated, receiving the injection, or whatever is necessary. Ask us how we feel instead of talking to our parents about us; we are capable of explaining our symptoms." This boy did not object to his parents coming with him but he wanted questions directed to him, the patient. Most of the young people expressed themselves well and felt we should not be critical of their attire so long as they were neat and clean.

The world of today is far removed from the world in which most adults grew up. It has been said if Booth Tarkington were writing SEVENTEEN today, it would have to be called *Twelve*. Modes of dress have changed. Manners and customs likewise have changed, not only for the teenager but for adults as well.

Even language has taken on new sounds, and while each generation has devised its slang, or its own type of talk, several of these words end up being used by people of all ages and eventually become absorbed into our culture. Many of us still use terms that "date" us and today's generation seems determined to stand out as a completely separate group. Here are a few words and phrases which you might hear:

nitty gritty *down to brass tacks*
hairy *difficult, grotesque*
sock it to me *give it to me straight*
cop out *shirk responsibilities*
bread *money*
put down *humiliate*
wheels *a car*

And while it may be helpful to know how to interpret some of this lingo, there's an important point to remember—the youngsters resent *non-turned-on* adults using it. To them, you have your own *bag* or *thing* and they have theirs.

Young people, particularly students, have always been out of step with the so-called establishment. It has often been through youthful dissent that fresh ideas and values have evolved. Way back in the time of Socrates, groups of young people were dissatisfied with the way things were run and their physical and vocal protests came from a desire to express their individuality. This does not mean we can or should tolerate blatant disrespect for law and order, but we need to listen to these young patients—don't *tune them out.* Don't disregard them when they have an appointment with "oh, they're just kids"—many of these young people have part-time jobs and other responsibilities; they need to be on time as much as anyone else who comes to the office. Can we expect them to be punctual and considerate if we treat them as someone just taking up a chair in the reception room?

Even though we may not understand all they say and may not always agree with them, work at communicating with them and don't get *up tight* (nervous, insecure), if you're *not with it.* When the barriers are down, we are apt to find some of their basic values to be meaningful and a portion of their enthusiasm could rub off on the world and make it a better place. Pay particular attention to the teenager for the next couple of months, just see if when you get right down to the *nitty gritty* you don't find the majority of them are a pretty good group!

JEANNE D. GREEN

AAMA Certification

More than 400 individuals have now been certified as medical assistants, either in the clinical or administrative categories, or both. The 92 persons certified in Des Moines October 29 are from 26 different states.

Woman's Auxiliary News

Prexy's Postulations

September is the month of beginnings: the harvest of crops, a changing season, school, football, and the Auxiliary year with its first Board meeting. It was a pleasure to host the meeting in Ottumwa in keeping with the custom of holding one Board meeting a year in a different area of the state. Hopefully this custom will take the place of district meetings, and will increase interest in Auxiliary work on the state level. We have an outstanding group of women serving on the Board, coordinating efforts to promote good health at the grass roots level and seeking to meet the needs of others less fortunate.

In the first area, Mildred Leinbach and Mae Weis suggested ways in which we may attack environmental problems. I urge you to analyze your local needs by working with other organizations, city and county officials, and the news media to reduce pollution—to "love" the land, water and air. There are specific suggestions in the Auxiliary News from Mildred and Mae. Don't miss them and tell us if you know of other ways in which local communities can be active.

YUCATAN

After hearing about Yucatan from Bunny Wicks, through correspondence and in a slide lecture by Dr. Larry Mills, professor of art at Central College, the Board voted to support the Iowa Partners of the Alliance program. Yucatan is Iowa's sister state; Texas has Peru; Wisconsin chose Nicaragua.

We help these sister states by sending health care supplies that are desperately needed: drugs (samples from your husbands' offices, hospitals, and drug salesmen), equipment that is in good condition; e.g., the Ottumwa hospital administrator gave me a knife (scissors, really) for chest surgery, plus a physician's examining table, two baby cribs, a bed and a wheel chair, now if I can only find a way to transport these items to Boone, Iowa. Headquarters for the organization is in Boone where Jeanette Westfall, secretary of the Partners of the Alliance, lives. She is doing a tremendous job, has driven her own car loaded with supplies to Yucatan several times, and works unceasingly to supply the needs of this country.

Anything that can be used in a hospital or clinic is needed. Kay Kent, our International Health Chairman, will be writing each county chairman or president about the project, and I hope each member-at-large, individually or through the councilor in her area, will make herself a committee of one to find something for Yucatan.

The organization, Partners of the Alliance, can always use money for transportation. Support the activities it sponsors in any way you can. Governor Ray made a trip to Yucatan and the Iowa State Fair will feature Yucatan next year. If you can bring your offerings to Des Moines, Auxilians Bunny Wicks and Mary Drew, who is President of Polk County, will get them to Boone for us. This is a specific focus for our efforts to "Serve Someone Somewhere" away from home.

There were some interesting reports from councilors and county presidents at the Board meeting. Urge your fellow doctors' wives to work in any way they choose to further health needs at home and abroad. Perhaps if you show them what the Auxiliary is doing they will "rush" to join us because our combined efforts do produce more muscle.

Have a good November and as we gather with our families for a festive Thanksgiving may we remember the needs of others and the world's need for Peace.

MARION PREWITT

Drug Abuse Workshop

A November workshop at the University of Iowa will consider the causes of drug use and give attention to ways in which better communication may be achieved between drug users and the professionals who hope to help them.

The two-day workshop will be held November 11 and 12 at the Memorial Union at The University in Iowa City. The workshop is a project of the School of Social Work in cooperation with the Colleges of Medicine and Education and other areas of the University.

Joel Fort, M.D., of the Center for Solving (Special) Social and Health Problems in San Francisco, California, will be the principal speaker.

Pollution Study

Added to Rural Health's 1970-71 Program

In an attempt to become knowledgeable about the new Auxiliary concern—Pollution—we would like to provide some introductory material from expert sources. A few simple suggestions for basic projects should be helpful as we move into a new and temporarily "murky" area of study.

A middle course seems more reasonable than the frightful prediction of Paul Ehrlich who says we may have no more than 15 or 20 years to live on this planet, as we know it. There are apathetic individuals who close their ears and eyes to mounting evidence of environmental deterioration and smugly assume that the "good life" will go on forever.

The following is a quote from a recent issue of the National Wildlife Federation magazine: "Man made miracles have made it easy for us to believe that we have created our own environment and now can ignore nature. The sober truth is that our modern technology has come at a high price: The unwitting but insidious deterioration of our physical world. Unless we immediately zero in on this problem with our most powerful technological guns, we run the risk of destroying this earth as a desirable place for life and the pursuit of happiness. The so-called 'good life' of this modern age is robbing us of our clean air and pure water, abundant minerals and fertile soil, diverse wildlife and green forests."

We know our *Environmental Quality* is shifting downward rapidly and in an attempt to pinpoint our awareness here, the National Wildlife Federation has compiled its first annual index of E.Q. On an evaluation scale ranging from Very Bad to Excellent, our E.Q. was rated as follows:

AIR—Very Bad
WATER—Bad
SOIL—Fair
FORESTS—Fair
WILDLIFE—Fair
MINERALS—Good

In summation, our 1969 E.Q. Index was *POOR!* What will it be in 1970?

The answer may very largely be up to women like ourselves who are concerned yet uncertain as to how we might be able to change this threatening situation. We might quote Pogo: "We have met the enemy and they are us!" If we recognize this fact, we shall at least have made a beginning. As our acquaintance with the problem grows, we



HEALTH SERVICE WINNER—Mrs. Gary Bousman, center, of Knoxville, is presented a silver tray as recipient of the Woman's Auxiliary 1970 Volunteer Health Service Award. Mrs. Bousman is active in various community programs and has given particular support to activities for senior citizens. Shown with Mrs. Bousman are Mrs. John E. Griffin, 1970-71 President of the Marion County Auxiliary, left, and Mrs. Dwight A. Mater, 1969-70 President.

should seek to learn what WE can begin to do about it. Here are a few practical suggestions for you—we must start somewhere.

1. Refuse to accept throw-away bottles at the supermarket.
2. When cans are used, cut out both ends and flatten them before placing in the garbage.
3. Stop using glamorous colored toilet tissues and revert to white as these are much more soluble.
4. Check the phosphate rating of your favorite laundry detergent. Have you seen a rating scale? (Write us if you'd like this.) If it is high, switch to one of the lower enzyme content products. If your water is very soft, you might even go back to soap—many experts urge this. Shades of our grandmothers!
5. Don't automatically use your dishwashers. Dishwasher detergents are very high in phosphate content. Wash dishes by hand more often.
6. Guard jealously wild life refuges or native, wooded areas and try to prevent further encroachments upon them. Many localities are making this a community project.
7. If you have a second home on a favorite lake or river, check its degree of pollution. If it's bad, organize a resident activity group and work together for cleaner conditions before you lose your waters to pollution. Many lakes today have predictably short lives ahead of them.
8. Don't be trigger happy with sprays. Decide whether you need to use pesticide or herbicide sprays at all. If you do, use them with more care and discrimination. Know your sprays. Some have shorter lived chemicals than others—e.g. malathion and diazon. Diazon, however, is peculiarly toxic to birds so be cautious where it is used.

Most of these suggestions we have taken from our ecology clippings. These are just beginnings. We would like to add your successes or frustrations to our ecology file or try to answer your questions, if we can. So let us hear from you.

Projects in improving our environment should be made to order for Auxiliaries. We like to feel we are intelligent, informed women, and we have a long line of successful projects BEHIND us. This should encourage our massing for an attack on a new battle front, so let's get to work! Let's have an exciting story to tell at the end of our year!

MILDRED LEINBACH (MRS. S. P.)
Rural Health Chairman
R.R. 1
Belmond, Iowa 50421

MAE WEIS (MRS. HOWARD)
Rural Health Co-Chairman
Steepmeadows, Box 278
Rock Island, Illinois 61201

Around the Hawkeye State

Clinton County

The theme "Holly Ball" has been selected for the annual Charity Ball of the Clinton County Medical Auxiliary.

Mrs. Juergen Holl will serve as Ball chairman. She will be assisted by Mrs. Kermit Sorenson and Mrs. Gary Schmunk, decorations; Mrs. Robert Nelson, finance; Mrs. George Ellison and Mrs. J. J. Young, food; Mrs. W. H. Griffith and Mrs. William Meyer, invitations; and Mrs. Frank Rogers, publicity.

Proceeds from last year's Ball were divided among the Clinton County hospitals in ratio to the ticket sales of each city. Jane Lamb and Mercy Hospitals received $700 each, and DeWitt Hospital was presented $142.60. The proceeds from the annual Ball are given to the medical staffs of each hospital for the purchase of medical equipment.

Persons interested in receiving an invitation to the Ball may call Mrs. William Meyer, 1012 Ninth Avenue, North, Clinton.

Officers of the Auxiliary are Mrs. George Aurand, president; Mrs. Holl, vice president; Mrs. D. R. Schumacher, secretary; Mrs. Kermit Sorenson, treasurer.

Polk County

The annual Fall meeting of the Polk County Medical Society and the Woman's Auxiliary was held September 16 at the Des Moines Golf and Country Club. Approximately 290 people enjoyed the social hour and dinner. Entertainment was provided by Don Hoy and his Combo. This was a record attendance for our Fall party.

Dr. Ralph Hines, President of the Polk County Medical Society, conducted a short business meeting after introducing special guests, new members and other guests. Mrs. Edward J. Drew, our Auxiliary President, also extended a warm welcome to all members and guests.

It was announced there would be a joint dinner to conclude Mercy Day (October 21). The Mercy Day program included a full day of scientific presentations at the hospital and concluded with a social hour and banquet at the Hotel Savery.

We wish to thank Mr. Ed Kingery of Polk County Medical Society, Mrs. Donald Sweem, our Social Chairman, Mrs. Robert Foley, our Program Chairman and all other people who helped to make September 16 a lovely evening.

Praise from the President

My sincere thanks to all of you who helped make the September Board meeting so pleasurable. We are always indebted to Hazel Lammey and the IMS staff for their cooperation. Mr. Kent Jerome presented a new audio-visual presentation on IMPAC at a joint dinner meeting with the Wapello County Medical Society and Auxiliary.

Helen Moress, President of the Wapello County Auxiliary, Mary Emanuel, Julie Emerson, Marge Hastings, Nancy DeKraay and Vie Scott served a delicious luncheon on September 22; Helen Austin served coffee and cookies on September 21 and rolls and coffee the following morning. Thanks, gals, I couldn't have done it without you!

Dr. Larry Mills, Central College, Pella, presented an informal lecture (with slides) on Yucatan. He was a delightful guest who brought us much information about our sister country in the Partners of the Alliance project.

Please plan to attend the January Board meeting January 12, 1971 in the home of Jeanne Coughlan in Des Moines. That will be a delightful occasion and we will have interesting news from our officers and committee chairmen.

The Little Red Hen (Revisited)

(Doug Smith, a British Columbia writer, produced this variation on the children's classic.)

Once upon a time there was a little red hen who scratched about and uncovered some grains of wheat. She called her barnyard neighbors and said, "If we work together and plant this wheat, we will have some fine bread to eat. Who will help me plant the wheat?" "Not I," said the cow. "Not I," said the pig. "Not I," said the duck. "Not I," said the goose. "Then I will," said the little red hen, and she did.

The wheat grew tall and ripened into golden grain. "Who will help me reap my wheat?" asked the little red hen. "Not I," said the duck. "Out of my classification," said the pig. "I'd lose my seniority," said the cow. "I'd lose my unemployment insurance," said the goose.

Then it came time to bake the bread. "That's overtime for me," said the cow. "I'm a dropout and never learned how," said the pig. "If I'm the only one helping, that's discrimination," said the goose. "Then I will," said the little red hen, and she did.

She baked five loaves of fine bread and held them all up for the neighbors to see. They all wanted some, demanded a share. But the red hen said, "No. I can rest for awhile and eat the five loaves myself." "Excess profits," cried the cow. "Capitalistic leech," screamed the duck. "Company fink," grunted the pig. "Equal rights," yelled the goose. And they hurriedly painted picket signs and marched around the little red hen singing, "We shall overcome." And they did.

For when the farmer came, he said, "You must not be greedy, little red hen. Look at the oppressed cow. Look at the disadvantaged duck. Look at the underprivileged pig. Look at the less fortunate goose. You are guilty of making second-class citizens of them." "But . . . but," said the little red hen, "I earned the bread." "Exactly," said the wise farmer. "That is the wonderful free enterprise system; anybody in the barnyard can earn as much as he wants. You should be happy to have this freedom. In other barnyards, you'd have to give all five loaves to the farmer. Here you give four loaves to your suffering neighbors." And they lived happily ever after, including the little red hen, who smiled and clucked: "I am grateful. I am grateful."

But her neighbors wondered why she never baked any more bread.

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Personals



Dr. Robert H. Kuhl, a Creston surgeon, recently received a plaque in honor of his 12 years of service on the Board of Directors of Blue Shield. A dinner with officials of Blue Shield and local physicians marked the occasion. **Dr. C. V. Edwards**, of Council Bluffs, made the presentation as Chairman of the Blue Shield Board. **Dr. W. A. Fisher**, of Creston, is succeeding Dr. Kuhl on the Board.

Dr. Burns M. Byram, a general practitioner in Marengo, was among the pilots competing during September in the Harold's Transcontinental Trophy Dash from Milwaukee, Wisconsin to Reno, Nevada. Flying a P-51D Mustang, a World War II fighter plane, Dr. Byram placed fourth in the race last year, covering the 1,667 miles in 5 hours, 53 minutes and 6 seconds at an average speed of 283.2 m.p.h. In 1968 he earned the third-place trophy.

Dr. A. S. Owca, of Centerville, spoke on drug use and abuse at a recent meeting of the Centerville Rotary Club.

Dr. Samuel J. Fomon, professor of pediatrics at the U. of I. College of Medicine, has received a $23,951 grant for research into the composition of commercial infant food. Dr. Foman will be assisted by **Dr. L. J. Filer**, professor of pediatrics, and **Dr. T. A. Anderson**, an assistant professor of pediatrics.

Dr. Donald Greif has assumed the ophthalmologic practice in Waterloo of **Dr. Gardner D. Phelps**, who recently retired. A native of Independence, Dr. Greif was graduated from the U. of I. College of Medicine in 1964. Following an internship at Milwaukee County Hospital, he took a residency in the Department of Ophthalmology at the U. of I. Dr. Grief has been an instructor on the ophthalmologic staff at the U. of I. College of Medicine and will remain a research consultant for the Department.

Dr. Harold Brereton, of Emmetsburg, was honored as a 50-year Mason at a recent meeting of Earnest Lodge. He was presented a 50-year certificate and pin commemorating the occasion. Dr. Brereton spoke at the meeting on delinquency in the nation's colleges and towns. He said the problem is partially the fault of parents, and he emphasized that parents and citizens need to work with youth to provide guidance and discipline.

Dr. Lloyd Smith, a Council Bluffs physician, has been elected to the Council Bluffs School Board.

Dr. Richard H. Winter, a dermatologist, has joined the Newton Clinic. Dr. Winter is the first such specialist to practice in Newton. A native of Sioux City, Dr. Winter attended Iowa State University and entered the U. of I. College of Medicine in 1957. He interned at Kansas University Medical Center and followed this with two years at Fort Hood, Texas, as an Army general medical officer. He practiced in Redlands, California, from January, 1965 to May, 1967, and then returned to the U. of I. for postgraduate training in dermatology. Dr. Winter is presently associated with the Department of Allergy at the U. of I. College of Medicine two days a week.

A symposium on neurology honoring **Dr. Adolph L. Sahs**, professor and head of the Department of Neurology at the U. of I. College of Medicine, occurred September 11-12. A portrait of Dr. Sahs, suggested and commissioned by present and former resident physicians and faculty of the Department, was presented to the University at the symposium. **Dr. Maurice W. Van Allen**, professor of neurology, made the presentation. A medical graduate of the U. of I. College of Medicine, Dr. Sahs joined the faculty in 1933. He became professor and head of the Department of Neurology in 1947. Dr. Sahs has served as president of both the American Neurological Association and the American Academy of Neurology of which he was a founding member.

Dr. Sharfuddin Shah, of Bombay, India, who is presently on the staff at the Mental Health Institute of Clarinda, was guest speaker at a recent meeting of the Page County Medical Society. Dr. Shah received most of his education in England and he described the difficulties of practice there under the National Health System.

Dr. David M. McCoy, who has been practicing in Lake City for the past several months, joined the Carroll Medical Center as a general practitioner in September. A native of Carroll, Dr. McCoy was graduated from the U. of I. School of Medicine in 1965. He served in the Army Medical Corps following his graduation and attained the rank of major. Dr. McCoy has taken special work in radiation therapy at the U. of I.

Dr. D. E. Tyler, Fort Dodge internist, has been appointed director of the Poison Control Center at Bethesda General Hospital to fill the vacancy created by the resignation of **Dr. C. J. Baker.** Dr. Baker resigned recently to make his home in Arizona, after serving as director of the Center since its establishment in 1961.

Dr. Edward Hertko, Des Moines internist, was guest speaker at the first of four classes held in Keokuk for people with diabetes mellitus. The series was also open to the families of diabetics and others who cook or care for diabetic patients. The classes are sponsored by St. Joseph and Graham Hospitals in Keokuk.

Dr. Dean Finken, of Cedar Rapids, presented a film on "Cardio-Pulmonary Resuscitation" at a recent dinner-meeting of the Linn County Association of Medical Assistants. Dr. Finken is program chairman of the Linn County Heart Association.

At the September meeting of the State Board of Health, **Dr. Franklin H. Top,** of Iowa City, was re-elected president and **Dr. E. E. Gamet,** of Lamoni, vice-president.

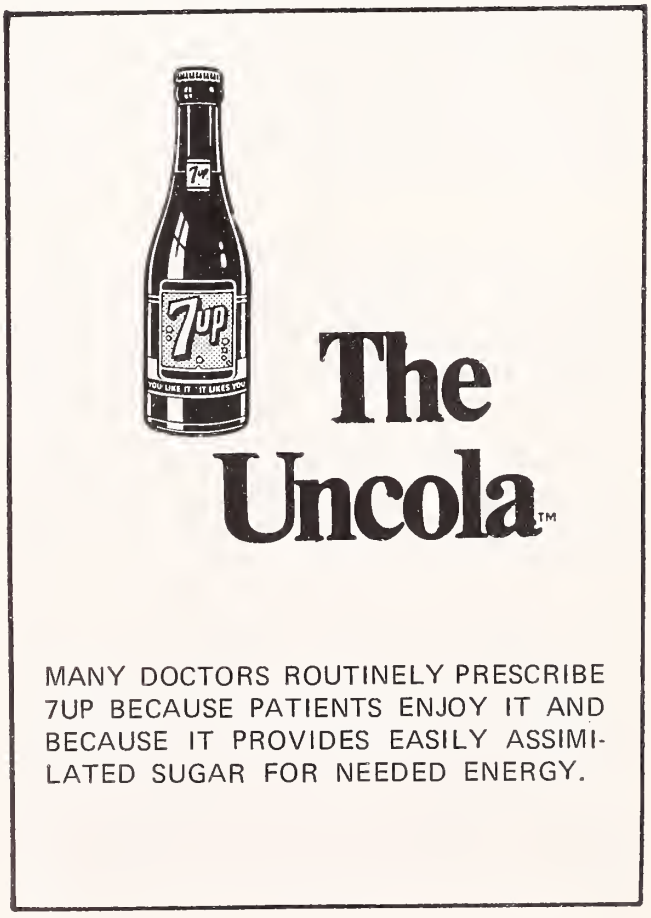
Dr. Charles Fail, of Adel, spoke on drug abuse at a recent meeting of the Adel Rotary Club. Dr. Fail told the group drug abuse is now spreading to smaller communities like Adel.

Dr. Alfred Healy, associate medical director of University Hospitals School at Iowa City, was a recent guest speaker at an educational program on birth defects held in DeWitt. The program was sponsored by the Clinton County Chapter March of Dimes. The University Hospitals School has just completed a half-hour color, 16 mm. sound film titled, "A Time to Heal." The DeWitt presentation was the first public showing. The film describes the daily activities of the children at the Hospitals School, both from a therapeutic and recreational standpoint.

Dr. George Aurand, of Clinton, participated in a panel discussion on therapeutic abortion at a day-long workshop held during September at the Des Moines YWCA.

Dr. H. P. Gulesserian, an assistant professor of surgery at the U. of I. College of Medicine, was guest speaker at the fall meeting of the Henry County Chapter, American Cancer Society, Iowa Division, Inc. Dr. Gulesserian's topic was "Leukemia."

Drs. E. G. Nafziger, Dale R. Wassmuth, and **Don E. Boyle,** all of Sioux City, spoke on shock and the unconscious patient and chest and abdominal in-



juries at an Emergency Care Seminar held in that city recently. The seminar was sponsored by Western Iowa Tech, the Iowa State Committee on Trauma, the American College of Surgeons, and the State Department of Health.

Dr. H. A. Van Hofwegen, of Newton, was guest speaker at the October Central Division meeting of the Iowa Heart Association. His subject was "Modern Medicine Looks at the Heart."

Dr. Merton Johnson has sold his interest in the Johnson Clinic in Nevada and will retire from general practice. His partners, **Dr. Robert Eggers,** and **Dr. David Stearns** have purchased the clinic operation and will operate it under the name of "Family Practice Center."

Dr. Hans Zellweger, professor and head of the Department of Pediatrics at the U. of I. College of Medicine, spoke at a meeting in Cedar Falls of the Black Hawk County Association for Retarded Children. His topic was "Genetic Counseling."

Dr. Robert Bittle, assistant professor of psychiatry at the U. of I. College of Medicine, was the keynote speaker at a youth seminar held in Atlantic recently. The seminar was sponsored by the Governor's Commission on Children and Youth with assistance from the Extension Service and the Atlantic Junior Federated Club.

At a recent meeting of the Tama County Medical Society, **Mr. David Elderkin,** a Cedar Rapids attorney and legal counsel for the Medical Protective Co., of Fort Wayne, Indiana, addressed the group on "Medical Malpractice." Guests of the Society were members of the Tama County Bar Association and their wives and special guests were the newly appointed judge of the 17th Judicial District of Iowa, the **Honorable John L. Hyland** and **Mrs. Hyland.**

Dr. Lawrence DenBesten, associate professor of surgery at the U. of I. College of Medicine, spoke on "The Christian Teacher's Responsibility to Spaceship Earth," at the October meeting of the Midwest Teachers Association held in Grand Rapids, Michigan. On November 5, Dr. DenBesten will present a paper on "Diet-Induced Cholesterol Gallstones in Prairie Dogs," at a meeting of the Central Society for Clinical Research in Chicago.

Dr. Donald VanEtten, a general surgeon at the Park Clinic in Mason City, was guest speaker at a recent meeting of the Wright County Medical Society. Dr. VanEtten spoke on his 4 years' experience at the Mission Hospital on the Persian Gulf. Special guests at the meeting were **Dr. and Mrs. John Christensen,** of Menlo Park, California. Dr. Christensen, formerly of Eagle Grove, is a life member of the Society.

Dr. Leslie Bernstein, professor and chairman of the Maxillofacial Plastic Surgery Section at the U. of I. College of Medicine, received the Award of Merit of the American Academy of Ophthalmology and Otolaryngology at the group's annual meeting in Las Vegas in October. Dr. Bernstein was presented the award for "services to the Academy and its educational programs." Before joining the U. of I. faculty in 1960, Dr. Bernstein was associated with the Wernher Research Unit on Deafness, the National Hospital for Nervous Diseases, and Kings College Hospital in London. He was recently elected vice-president of the International Association of Maxillofacial Surgeons.



In honor of his 25 years of service to the Fonda community, **Dr. J. B. Thielen** has been named honorary chairman for Fonda's 100th birthday celebration. Dr. Thielen received the M.D. degree from the U. of I. College of Medicine in 1935. Following graduation he interned for one year at Mary's Help Hospital in San Francisco, California, and then took an additional year in surgery. He remained in San Francisco for eight more years. In 1945, at the suggestion of the War Manpower Commission, Dr. Thielen and family moved to Fonda. He served as mayor of Fonda from 1956 to 1960. Dr. Thielen was honored in 1962 with an appointment as a Knight of St. Gregory by Pope John XXII.

Dr. James G. Baumann, of Charles City, will serve as full-time Emergency Department physician at Mercy Hospital in Iowa City. A 1943 grad-

uate of the U. of I. College of Medicine, Dr. Baumann served with the Army Medical Corps during World War II and practiced at Riverside before moving to Charles City in 1947.

Dr. F. L. Coyle has joined Surgical and Orthopaedic Associates in Waterloo. Dr. Coyle, a thoracic and cardiovascular surgeon, received the M.D. degree at St. Louis University School of Medicine in 1959 and served his internship and general surgery residency at St. Louis University Hospitals. He received his thoracic surgery training at Wilfordesat Hall, U.S.A.F. Hospital, in San Antonio, Texas. Dr. Coyle, who served in Viet Nam in 1968-69, was recently discharged from the U. S. Air Force.

Dr. David Decker has become associated with **Drs. G. F. Canady, A. A. Knosp** and **L. L. Marshall** in the practice of medicine at Jefferson. A graduate of the U. of I. College of Medicine, Dr. Decker served his internship and general practice residency at Broadlawns Hospital in Des Moines. Dr. Decker served a year in Viet Nam as an Army doctor and recently terminated his military duties at Fort Leonard Wood, Missouri.

Drs. S. F. Guiang, G. M. Gibbs, Bernardo Pineda and **Curtis Nessa,** all Burlington physicians, recently participated in a five-session smoking withdrawal clinic in Burlington; the clinic was sponsored by the Des Moines County Tuberculosis and Respiratory Disease Association.

Dr. Charles Mayhugh has joined the staff at the Avoca Medical Clinic. A 1968 graduate of the U. of I. College of Medicine, Dr. Mayhugh interned at St. Luke's Hospital in Denver, Colorado, until 1969 and received the Master's Degree in Medicine at Johns Hopkins University in Baltimore, Maryland, this June.

Dr. Volney W. Hash has become associated with Medical Associates in Dubuque in the practice of cardiology and internal medicine.

Dr. Ian M. Smith, professor in the Department of Internal Medicine at the U. of I. College of Medicine, recently attended an international symposium at the Royal College of Physicians in London, England. An important new group of antibiotics called the cephalosporins were discussed and Dr. Smith spoke on cephalosporin therapy of staphylococcal infections in adults.

Two U. of I. College of Medicine staff members, **Dr. William E. Connor,** professor of internal medicine, and **Dr. Arthur A. Spector,** assistant professor of internal medicine and biochemistry, chaired a symposia on "Lipids, Platelets, and Thrombosis" and "Atherosclerosis and Lipid Metabolism" at a joint meeting of the World Congress of International Society for Fat Research and American Oil Chemists Society in Chicago. Dr. Connor also spoke on "Sterols in Blood and Arteries" and Dr. Spector presented a paper on "Free Fatty Acids and Platelets." **Dr. John C. Hoak,** professor of internal medicine at the U. of I., co-authored the latter paper.

Dr. B. D. Faustino has joined **Drs. C. H. Denser, Jr.,** and **M. A. Meservey** in the practice of pathology at the Clinical Pathology Laboratory in the Des Moines Medical Center. Dr. Faustino was graduated from the Major National University of San Marcos School of Medicine in Lima, Peru, in 1957. He served two years in pathology training at the University of San Marcos and completed his residency in anatomic pathology at the University of Cincinnati, Cincinnati General Hospital in Ohio. After four years of private practice in Lima, Peru, he became assistant pathologist and instructor at Baylor University College of Medicine in Houston, Texas. Dr. Faustino completed his residency in clinical pathology at the State University Down State Medical Center in New York City in 1970. He is certified by the American Board of Pathology in Anatomic Pathology and Clinical Pathology.

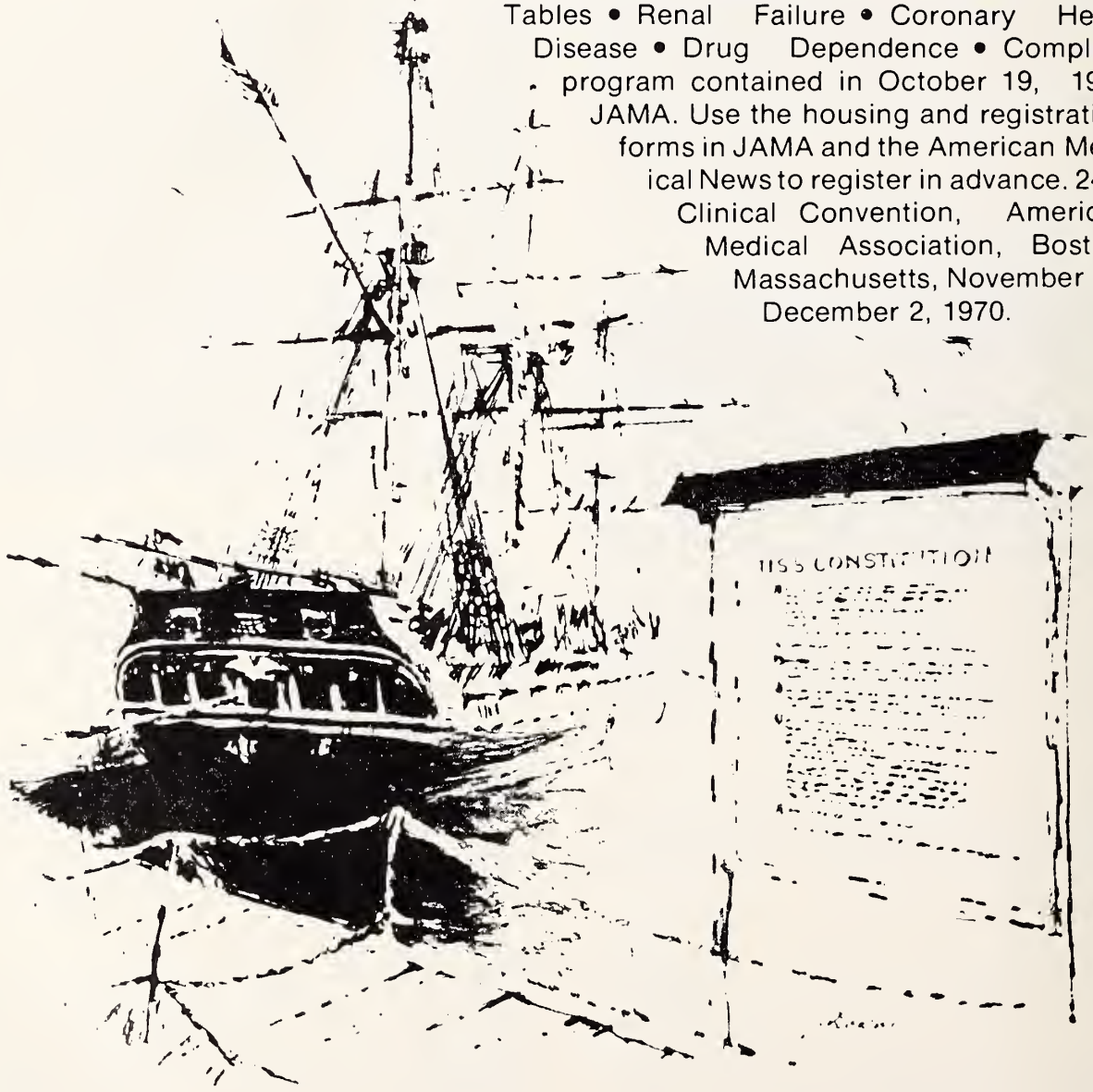
Dr. Lewis E. January, professor of internal medicine at the U. of I. College of Medicine, was elected vice-president of the International Cardiology Federation at the sixth World Congress of Cardiology in London, England.

Dr. Charlotte Fisk, a Des Moines pediatrician, has been named Head Start consultant for the Leon and Ottumwa project areas by the American Academy of Pediatrics. Dr. Fisk is medical director of the Des Moines Speech and Hearing Center.

The following Iowa physicians were inducted as new Fellows of the American College of Surgeons at the 56th Annual Clinical Congress of that organization held in Chicago in October. They are: **Dr. Massoud M. Shahidi,** of Ames, **Dr. Donald J. Ahrenholz,** of Cedar Falls, **Dr. Robert J. Martin,**

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of Cherokee, **Dr. Donald W. Cline**, of Creston, **Dr. Dennis L. Miller**, of Davenport, **Drs. James W. Hopkins, Matthew P. Lawler, Jr.**, and **Richard C. Johnston**, of Des Moines, **Drs. Luke C. Faber, Brent J. Holleran, Clark W. Stevens**, and **James W. White**, of Dubuque, **Drs. Hrair P. Gulesserian** and **Robert D. Whinery**, of Iowa City, **Dr. Robert L. Mandsager**, of Marshalltown, **Drs. Harold E. Cahoy** and **Samuel D. Porter**, of Mason City, **Dr. Carol L. Plott**, of Spirit Lake, and **Dr. William E. Hall**, of Waverly.

Dr. R. M. Quetsch, of Cedar Rapids, and **Dr. H. S. Frenkel**, of Clarinda, president and president-elect of the Iowa Clinical Society of Internal Medicine, attended a recent regional meeting of the American Society of Internal Medicine in Scottsdale, Arizona.

Deaths

Dr. Gaylord R. Andre, 58, died September 2. Dr. Andre received his M.D. degree at the University of Iowa in 1936, interned at Methodist Hospital in Madison, Wisconsin, and engaged in private practice in Lisbon before joining the U. of I. Student Health Department in 1966.

Dr. W. H. Clary, 88, of Prescott, died September 6 at Longmont, Colorado. A veteran of World War I, Dr. Clarey had been in ill health for some time. He was a life member of the Iowa Medical Society.

Dr. William W. Weber, 83, longtime Pomeroy physician, died September 16 at Mercy Hospital in Fort Dodge. Dr. Weber attended the University of Iowa and was graduated from the University of Kansas City Medical School. A World War I veteran, Dr. Weber lived in Minnesota before coming to Pomeroy in 1921. He was a member of the American Legion, a charter member of the Calhoun County Veterans of World War I and a former member of the Pomeroy School Board.

Dr. William H. Megorden, 56, died suddenly of an apparent heart attack at his home on September 19. A native of Waukon, Dr. Megorden received the M.D. degree at the U. of I. College of Medicine in 1938, and had practiced in Mt. Pleasant for 32 years. He was a member of the Board of Directors of the Southeastern Iowa Area Community College in Burlington and a member of the Board of Trustees and Executive Board at Iowa Wesleyan College.

Dr. Theodore J. Greteman, 65, a Dubuque orthopedic surgeon, died September 30 at a Dubuque hospital. Dr. Greteman was associated with the Department of Orthopedic Surgery at the U. of I. College of Medicine before coming to Dubuque. He received the M.D. degree in 1929 at Loyola University in Chicago.

Dr. Otto Schott, 86, died at his home in Lansing following an extended illness. Dr. Schott practiced surgery for many years in Chicago and Wisconsin before retiring in 1956 at his home town of Lansing. A World War I veteran, Dr. Schott received the M.D. degree at Loyola University in Chicago. He was a member of the American Medical Association, Wisconsin State Medical Society, and a fellow in the American Geriatric Society.

Dr. Louis D. Cheney, 80, died September 2 at a California hospital. A 1915 graduate of the U. of I. College of Medicine, Dr. Cheney moved to California in 1922. He was a member of the Iowa Medical Society from 1919 to 1922 when he transferred to the California Medical Society.

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No charge is made for the ads of members, wives of deceased members of the Iowa Medical Society or physicians seeking Iowa locations; for others the cost is $1.00 per line, $5.00 minimum per insertion. Copy for ad must be received by the seventh of the month for the following issue. Send to JOURNAL OF THE IOWA MEDICAL SOCIETY, 1001 Grand, West Des Moines 50265.

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WANTED: Used operating table for office minor surgery. Contact William E. Owen, M.D., St. Ansgar, Iowa 50472. Phone 736-4401.



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The SAMA News
a start at communicating

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A most worthwhile mechanism for creating a memorial to a relative, associate, colleague or friend exists in the Scanlon Medical Foundation/Iowa Medical Society. The Foundation utilizes memorial gifts to carry forward its loan program which has helped more than 300 young Iowans finance their medical educations. The Foundation will be glad to send an appropriate card in the name of the donor to the family of the person honored. The tax-deductible memorial gifts should be directed to the Scanlon Medical Foundation/ Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

Index to Advertisers

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Robins, A. H., & Company 738A, B, 778, 778A

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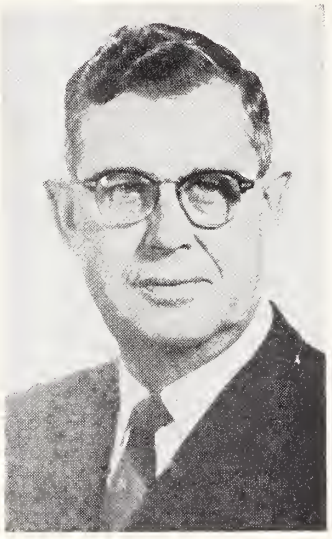
IN THIS ISSUE

- The U. of I. College of Medicine in the 70's—John W. Eckstein, M.D.
- Prevention of Urinary Infection in Patients With Indwelling Catheters—Joseph D. Schmidt, M.D.
- Tuberculous Peritonitis: Use of the Hook Needle Biopsy—David F. Gordon, M.D.
- Porphyria: The Little Mimic—An Interesting Case With General Review—Carl W. White, M.D., and Stephen P. Nicknish, M.D.
- 1970 JOURNAL INDEX



DECEMBER, 1970

President's Page



This is the season for the Christian world to celebrate the birth of its Savior. It is a time when all individuals can celebrate in their own fashion their own Savior. Our reflections at these times should include our reason for being.

I would hope that each and every one of us would strive to improve the lot of our fellow beings, as well as ourselves, so at the time of our exit from this universe we find it improved from the time of our entrance.

That is my prayer for each and every one and for the world as a whole at this time.

President



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(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.

The JOURNAL of THE IOWA MEDICAL SOCIETY

Vol. LX December, 1970 No. 12

CONTENTS

The College of Medicine in the 70's
John W. Eckstein, M.D. 802

SCIENTIFIC ARTICLES

Prevention of Urinary Infection in Patients With Indwelling Catheters
Joseph D. Schmidt, M.D. 815

Tuberculous Peritonitis: Use of the Hook Needle Biopsy
David F. Gordon, M.D. 819

Porphyria: The Little Mimic—An Interesting Case With General Review
Carl W. White, M.D., and Stephen P. Nicknish, M.D. 821

EDITORIALS

At Christmas and Beyond 829

Early Discharge of Surgical Patients 829

High Risk Obstetric Patient 831

SPECIAL DEPARTMENTS

President's Page 798

Doctor's Business 808

Iowa Medical Miscellany 809

State Department of Health 810

University Hospitals Drug Letter—Rubella Vaccines, Alfred Healy, M.D. 828

American Association of Medical Assistants, State of Iowa Inc. 833

Journal Book Shelf 834

Woman's Auxiliary News 836

Personals 840

Deaths 845

Index to Volume LX, 1970 851

In the Public Interest facing pace 854

Medical Meetings 855

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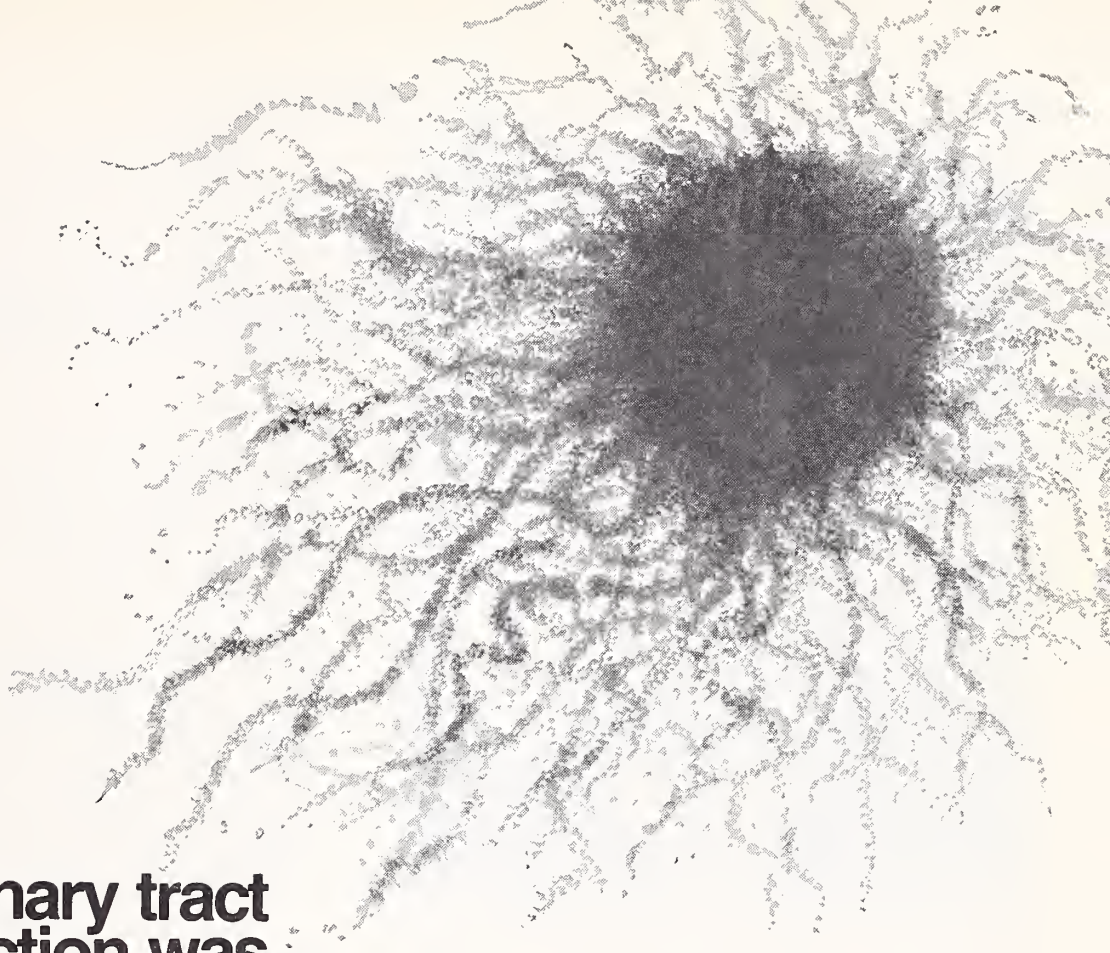
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

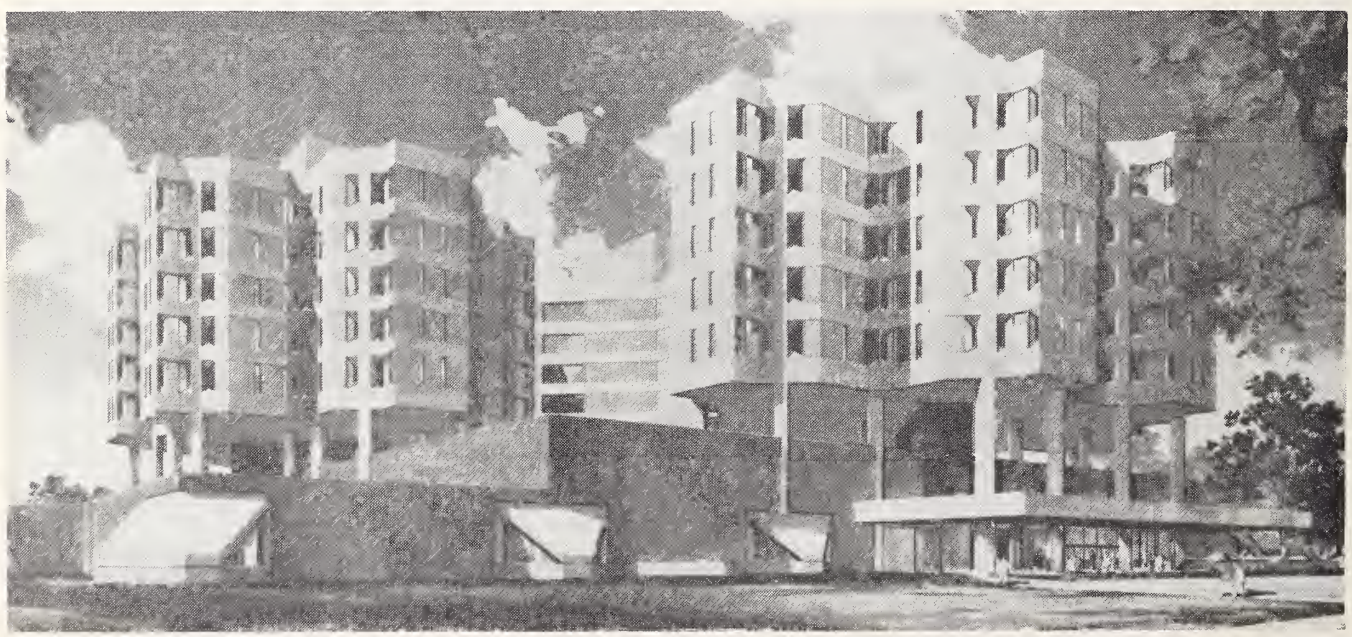
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The College of Medicine in the 70's

JOHN W. ECKSTEIN, M.D.
Iowa City

The College of Medicine is located on the West Campus of the University. We occupy the Medical Laboratories Building, the Medical Research Center, the Medical Research Facility, and we will occupy the Basic Science Building which is now under construction. Our faculty and students are based in these buildings as well as in the University General Hospital, the Veterans Administration Hospital, the Children's Hospital, the Psychopathic Hospital, the Hospital School, the Oakdale Hospital in the Iowa City area, and Broadlawns Hospital in Des Moines. By 1972, with completion of the Dental and Nursing Buildings, all the health colleges—Medicine, Dentistry, Nursing and Pharmacy—will be consolidated on the West Campus. Future plans for the Health Sciences Center call for a new University Hospital and a Library to complement the buildings I have mentioned.

"We are trying to give Iowa a new package in medical education—a new curriculum, formalized externship programs, a new department of family practice, a new department of community health, model clinics, expansion of allied health units, expansion of continuing education, educational affiliations with community hospitals and more doctors."



HOSPITAL EXPANSION—Shown here is a drawing of the planned addition to University of Iowa Hospitals. The addition will enlarge the hospital's capacity by 480 beds. It will include several clinics, a centralized operating suite, emergency and out-patient clinics, a pharmacy substation, classrooms and other supporting services. A $38.6 million budget has been approved by the Board of Regents. No state tax funds will be used for the project, financing for the most part will come from federal funds and revenue bonds.

The faculty of the College of Medicine is responsible for large blocks of the educational programs of the other health colleges and for the care of patients in our hospitals.

In 1969-1970 there were 497 students in medicine, 235 in dentistry, 454 in nursing, 300 in pharmacy, 285 in graduate programs (these include Ph.D. programs and also M.A. programs in nutrition, physical therapy, hospital and health administration and others) and 155 in baccalaureate programs in health fields, such as medical technology, microbiology, physical therapy and nuclear medicine technology. There were 262 residents, 40 interns and 46 fellows in training in our hospitals. There were 940 students from the College of Liberal Arts registered for courses offered in the College of Medicine. This amounts to about 3,200 regular students. In addition, our faculty constantly participates in short courses, workshops and programs in continuing education in almost all the health fields.

There are about 1,500 hospital beds in Iowa City for which our faculty is responsible. The annual patient load in these hospitals is divided into something like 36,000 admissions, 270,000 outpatient visits and 455,000 patient days. There are approximately 250 clinical faculty members and 85 faculty members in our preclinical sciences.

SOURCES OF SUPPORT

Our sources of direct support are state appropriated funds, approximately 5 million dollars; formula education grants from the federal government, 1 million; private practice earnings, 4.6 million; federal training grants, 2 million; federal research grants, 5 million; and about 1.5 million from a variety of non-federal gifts and grants.

A more simple breakdown, lumping federal dollars, would be 8 million from federal sources, 5 million from the state, 4.6 million from earnings and 1.5 million from these miscellaneous sources.

The College, although supposedly among the more stable of the medical schools, is really in a tight financial situation. Loss from any one of these sources would be serious.



It has been said we should not accept federal money and that we do too much research at the expense of teaching. About 25 per cent of the salaries of our faculty comes from federal research grants. If we did not have these grants we would not have 25 per cent of the faculty, and some of our best teachers are those who are able to attract research funds. It also has been said we are trying to deliver too much patient service. Approximately 27 per cent of our faculty salaries comes from earnings and some of our best teachers are those who are most heavily involved in patient care.

Federal training grants are disappearing and nothing is replacing them. Research money which supports an enormous amount of education is shaky. Teaching institutions are threatened with loss of Medicare payments for professional services. This amounts to approximately one-fourth of our earned income—and earnings have been a primary source of support for our educational programs since 1946. It is doubtful that the State alone can provide us with the increases to fill the gaps which

Dr. Eckstein became Dean in this Centennial Year of the College of Medicine. His comments here have been adapted from a talk made before the Johnson County Medical Society.

could be created very quickly in federal and earned income.

Against the background of financial uncertainty are our commitments. All the health colleges and the allied health units are projecting increased enrollments. We are developing new programs, new departments and new affiliations. All of these require dollars. Even our new medical curriculum calls for a greater financial outlay.

Despite the large number of dollars with which we work we are in a very inflexible position. Everything is budgeted and there are very few places to cut back. We must continue to teach nurses, dentists, pharmacists and allied health personnel, and we must develop new programs. We do not have an overpaid faculty and our staffing pattern is marginal when compared with similar medical schools. It is difficult to plan and to expand and to develop new programs in response to the pressure of the times with these financial stringencies before us.

CENTENNIAL YEAR 1870-1970
100
The University of Iowa
COLLEGE OF MEDICINE

USE OF TAX FUNDS

In connection with the mounting difficulty of financing medical education, I would like to comment on another matter. Most of you know that some physicians in Polk County and also the Osteopathic College will urge the Iowa Legislature to appropriate state tax funds to support the College of Osteopathic Medicine and Surgery in Des Moines. Newspaper articles seem to imply such action will have a significant impact on the physician shortage in rural areas and small towns within the State. It has been said that the Des Moines College has a demonstrated record of training family doctors and that a significant number of them locate in Iowa and practice in smaller communities. It also has been implied that the pattern of education offered by the Osteopathic College leads more students into family practice in rural communities.

We should look at the facts. What does happen to the graduates of the Des Moines College of Osteopathic Medicine and Surgery?

First of all the College has been graduating about 80 students annually in recent years. The class of 1967 numbered 68 and 10 of these were Iowa residents. There were 82 graduates in the class of 1969 and 8 of these were Iowans. The class of 1972 has an enrollment of 101 and 12 are from Iowa.

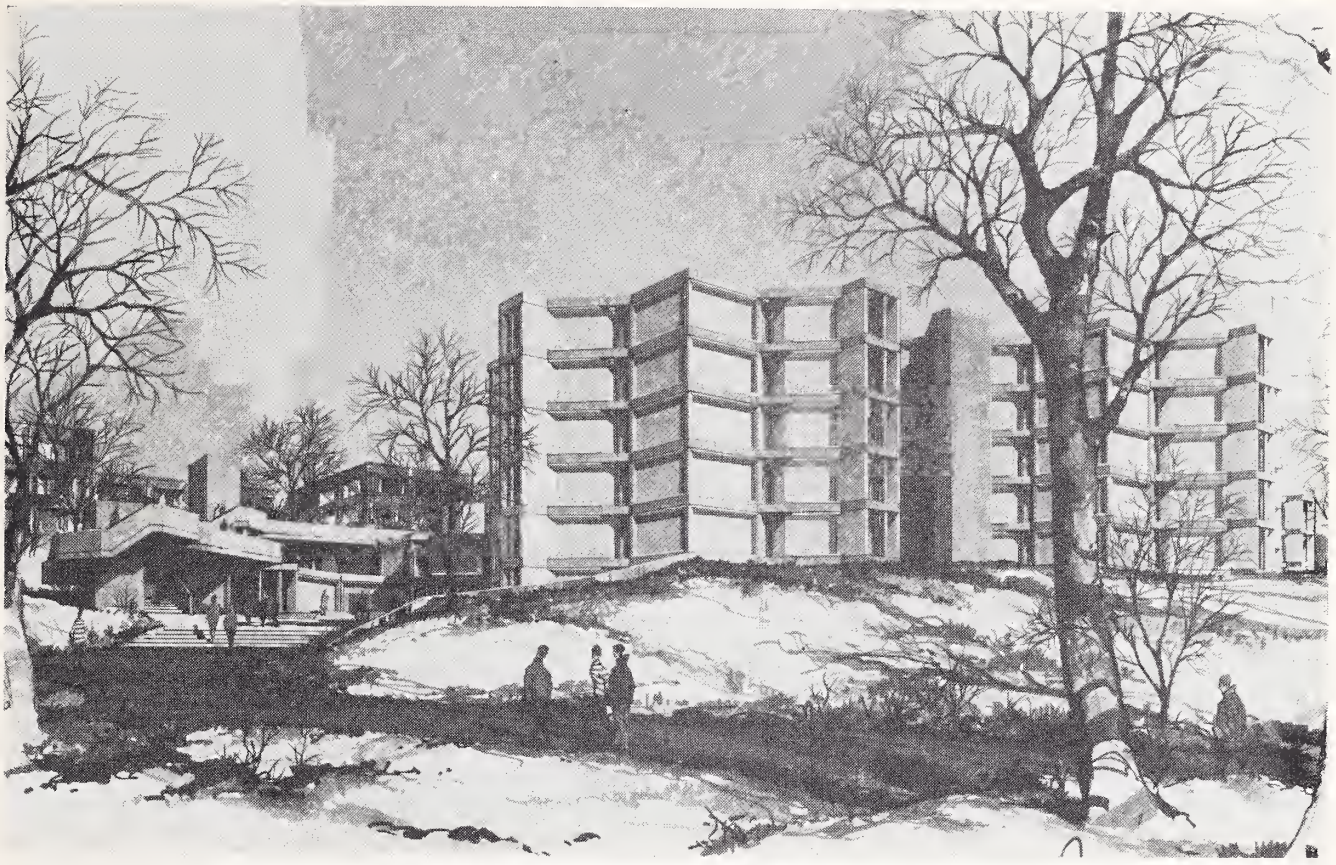
Graduates of the Osteopathic College do not remain in Iowa in large numbers. There are 22 graduates from the six classes from 1959 through 1964 who practice in Iowa. Fourteen of these are general practitioners and eight are specialists. Only 13 of the next five graduating classes (1965 through 1969) are practicing in Iowa. Five of these are in general practice; eight are specialists and eight of the 13 practice in towns over 25,000.

In 1969, 47 of the men who were graduated from the Des Moines College during the fourteen year period, 1955-1969, were practicing in Iowa. Of these 47, 23 were practicing in Des Moines and 2 in Davenport.

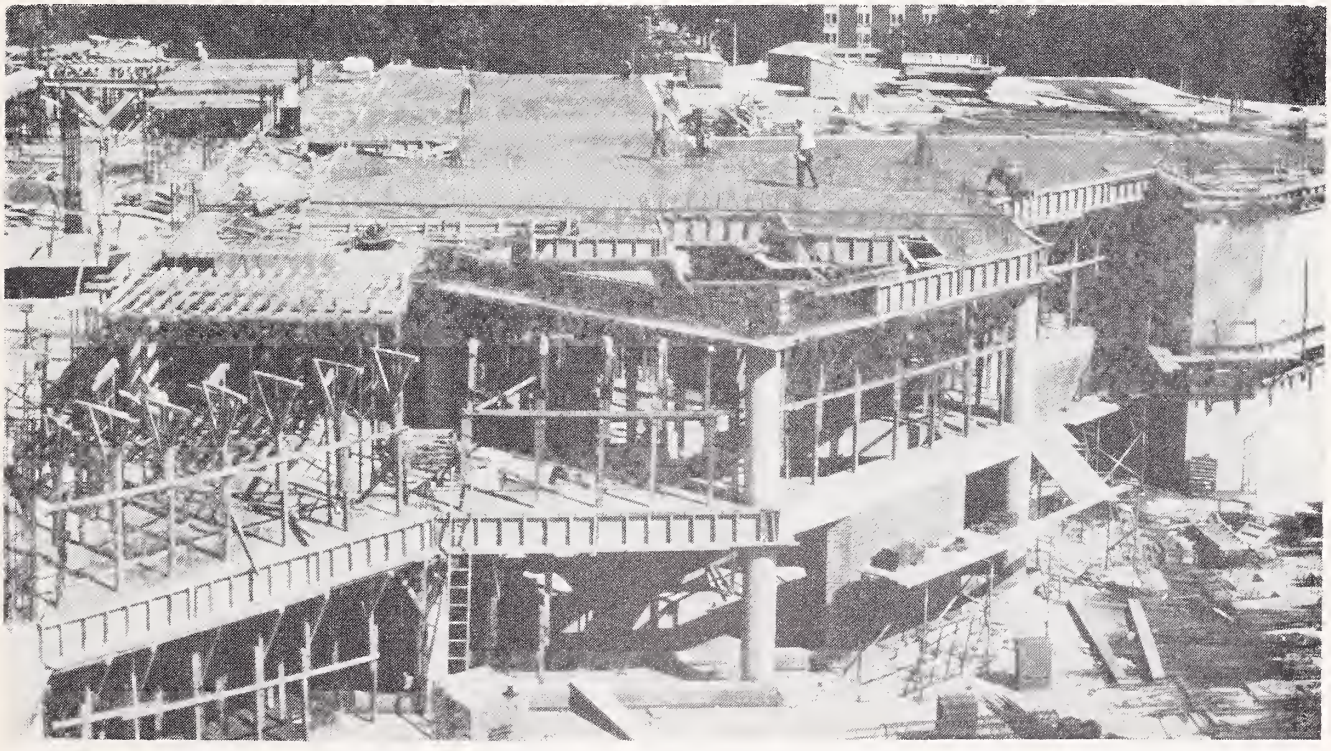
These facts indicate the trend among graduates of the Osteopathic College is toward specialization and practice in larger communities. The past record does nothing to support the belief that State tax funds for the Osteopathic College or the pattern of education in the College will lead to a significantly greater number of family doctors for rural Iowa communities.

EXPANSION ACTIVITIES

The need to increase the yield of Iowa practitioners has given rise to a number of specific steps now being taken in the College of Medicine, steps which have received the support of Iowans through their General Assembly in the form of commitment of funds to help with the building expansion, faculty growth, and other necessities of gearing up to meet the needs. One might ask the question, What is the Col-



BASIC SCIENCE BUILDING—This artist's conception provides an impression of how the Basic Science Building will look at The University of Iowa when completed in 1972. The $15.7 million five-level structure will house the departments of anatomy, physiology, microbiology, biochemistry and pharmacology. Two other health science buildings now under construction are the College of Nursing Building (to be completed in 1971), and the Dental Science Building (to be completed in 1972).



PROGRESS TO DATE—Actual construction of the Basic Science Building had progressed to this point by October. Architect for the structure is Walter A. Netsch, Jr., of Chicago, designer of the unique chapel at the Air Force Academy.

lege of Medicine doing or planning to increase the yield of Iowa practitioners?

First of all, we are increasing our enrollment. We accepted 145 students in the entering class this fall. This is 16 more than in the previous year. We also accepted 15 transfer students into the junior class making a total increase of 31 in a single year. In 1972 we will accept 160 in the first year and in 1973 we will accept 175. By 1976, without taking transfer students, we will have a total enrollment of about 700, an increase of about 40 per cent since 1969. It could be significantly greater if we can identify the necessary financial support and establish appropriate educational affiliations with community hospitals throughout the state.

Another development which should help attract students to family practice is the formation of the new Department of Family Practice. This is being done with the support of the Academy of General Practice. Preliminary plans for the family practice curriculum call for exposure of students to patients and their families beginning in the first year and continuing through the four years of medical school. We also are planning a model rural health clinic which can be used to test new ways to deliver health care to rural communities, and which can be used to train students with new skills to provide rural health care.

The new medical curriculum may influence students to think of family practice if the assumption that early patient contact is important in this regard. The new curriculum brings the student into the mainstream of patient care about a year earlier than was the case previously.

We are attempting to arrange a program for the summer following the first year of medical school to provide each student the opportunity to spend a week with a practitioner. It is obvious that the student will only be able to observe but we hope the experience will provide some insight into the advantages and attractions of practice at an early state. We are, of course, continuing the regular preceptorship program which has been in operation for many years.

Another project under consideration is a formalized, broad scale externship program. This would be to some degree an expansion of the present MECO Project. M.E.C.O. stands for Medical Education-Community Orientation. It is an interesting program. During the past summer 17 students, who had completed their freshman year, spent most of their vacation period working in 12 different community hospitals in Iowa. Participating hospitals were in such widely scattered locations as Manchester, Sioux City, Keokuk, Waterloo, Cedar Rapids, West Union, Corydon, New Hampton, Hamburg and Fort Dodge. Each hospital provides a 10-week program of educational activity so the student participates in the work of several departments and becomes involved in the delivery of health care.

Another program for the future is the development of educational affiliations with community hospitals. With 700 or more students in 1976 will come an increased need for clinical facilities. Also the larger number of students will lead to a greater demand for residency positions. If we want to keep the residents in Iowa we must try to provide the positions in Iowa hospitals.

Many of you know we are appointing physicians from Iowa communities to most of our standing College of Medicine committees. This will give our students and faculty the opportunity to receive direct input and thoughtful advice from those who face the problems of rural practice daily. I expect this simple step to have many beneficial effects for the College.

I have outlined some of our plans and thoughts which may be helpful in keeping our graduates in Iowa. We also hope to emphasize other programs which may lead to improvement of health care in the state. Expansion of our allied health units and increased emphasis on continuing medical education are notable examples.

We are trying to give Iowa a new package in medical education—a new curriculum, formalized externship programs, a new department of family practice, a new department of community health, model clinics, expansion of allied health units, expansion of continuing education, educational affiliations with community hospitals, and more doctors. All will require thought, planning, patience and dollars. If our planning is effective and if we can maintain and increase our financial base, we should see some interesting and exciting changes during the next decade.

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WHAT MAKES A PHYSICIAN SUCCESSFUL?

LARRY E. LEAVERTON
Des Moines

In observing physicians over many years we find certain factors in common among those whom we consider to be successful. Success means different things to different people. To most doctors it would mean successfully meeting the health needs of their patients and their communities. To others it means financial success. Still others think of success as prestige or security. Ease of practice in a satisfying profession would rank high on any list of common factors.

The successful physician in our opinion has most of these characteristics:

He is dedicated to his work, practicing good medicine, at a reasonable cost to his patients.

He has the knowledge necessary for his profession and he keeps up with new developments in his field and specialty. In any profession much of what was learned over 10 years ago is now obsolete.

He is well organized—in his professional and personal life.

He makes effective use of his time—he is busy but still has time for health organizations, civic responsibilities and for his family. There is a saying, "If you have a tough job to do, give it to a busy man—he will get it done." Frequently a number of outside commitments will force a person to organize his time. He gives time and financial support to charities. He has learned to say no, when he is over-extended. He is selective with his time.

He has established goals—and he has a plan to reach these goals, with short range and long range objectives and a timetable for achieving them.

He delegates—to properly trained assistants, all of the duties he can without detracting from the quality of care.

He educates his patients to his philosophy of practice. This philosophy must be workable and realistic.

He is a good communicator—to be a good communicator he must also be a good listener. In verbal communications, you have to have a speaker and a listener. There is so much emphasis on speaking and so little on listening. Faulty communications are the root of many practice management problems.

He is a good manager—if he has limitations in this area he enlists aid to assist him in managing his practice. He is open to new ideas which may improve the management of his practice.

He has a good loyal staff of assistants who also possess many of these same qualities, and he effectively utilizes their talents.

THE DOCTOR'S BUSINESS

He observes good public relations. Good public relations are very important in relationships with patients, employees and colleagues. Every patient is given prompt and courteous treatment insofar as possible. The entire staff is alert to any complaints about fees or expressions about inadequate or improper care. His office has the proper respect for the patient's time. The public relations-conscious office enjoys a good relationship with referring doctors, the hospital and the community. Reports, insurance forms and other information are given promptly and cheerfully.

He has a well designed efficient layout, comfortable for the patient and for the doctor's convenience, arranged for a smooth flow of traffic, and keyed to efficiency. He has an adequate number of examining rooms, fully equipped with all possible bottlenecks eliminated.

We have found that if the majority of these characteristics are present, financial success will follow.

If you do not possess all these characteristics of a successful physician—don't despair. The successful physician also seeks to improve himself constantly. It is never too late for improvement.

Mr. Leaverton is Director of Research and Development for Professional Management Midwest.

IOWA MEDICAL MISCELLANY

IMS delegates to the AMA are representing the Society this month at the interim meeting of the AMA House of Delegates in Boston. Iowa's elected delegates to the AMA are L. W. Swanson, M.D., Mason City; H. J. Smith, M.D., Des Moines, and E. M. Smith, M.D., Des Moines. C. E. Radcliffe, M.D., Iowa City, is the alternate delegate. Other Society officers are also involved in the December deliberations of the AMA House.

* * *

Nutrition research at the U. of I. has identified a relationship between the amount of cholesterol in a pregnant woman's diet and the amount found in her blood. So reported Martha Fry, a U. of I. research dietitian, at a cardiovascular symposium of the American Dietetic Association. In the study the amount of cholesterol in the diet of pregnant women was controlled; blood testing was then done to determine cholesterol level. Patient blood samples changed with the switching from high to low cholesterol diets. The study suggests diet restriction will help the pregnant woman keep her cholesterol level within the normal range.

* * *

"The city is not a fit place to live." This candid description of Chicago is attributed to V. L. Moldenhauer, M.D., now a practicing physician in Marengo. A woman doctor, Dr. Moldenhauer moved with her family to Iowa in August. Her husband is an assistant professor at Kirkwood Community College in Cedar Rapids.

* * *

William O. Rieke, M.D., chairman of the Department of Anatomy at The U. of I., has been named president-elect of the National Association of Anatomy Chairmen. Dr. Rieke served during a portion of 1970 as acting dean of the College of Medicine. The AAC is now studying some of the experimental anatomy curricula to see if it can be adopted nationally; the objective of the project is the eventual production of better health science students of all types at less cost per student.

The Muscatine County Medical Society has approved a heart disease research project which is to involve those children in grades three through 12 in the community's 14 schools. Objective of the study is to identify those children who might be prone to develop heart attacks, stroke, high blood pressure, obesity and diabetes in adult life. The U. of I. medical study will include as many as possible of the 5,500 Muscatine school children. Financial support is being provided by the Iowa Regional Medical Program. Principal investigators are William E. Connor, M.D., director of The U. of I. Clinical Research Center, and Ronald M. Lauer, M.D., Professor of Pediatrics.

* * *

In excess of 100 physicians attended the ninth annual Medical Associates Clinic Day in Dubuque November 12. Guest lecturer was Robert M. Kark, M.D., Director, Renal and Nutrition Section, Presbyterian-St. Lukes Hospital, Chicago. Papers were also presented by these Clinic physicians: A. J. Piasecki, R. A. Pfaff, F. D. Zahn, D. M. Keller, P. R. Whitis, R. L. Barton, R. A. Ott and D. F. Knapp.

* * *

Attention county medical society program chairmen! A new type of continuing medical education program is available from MED. COM. INC. Subject of depression is covered in this initial effort. Described as a total learning system, the program on depression includes (1) a 30-minute documentary film, (2) a comprehensive monograph of permanent reference value and (3) a self-evaluation section which enables the physician to test himself. Arrangements for use of the program may be made through Dennis M. O'Brien, Senior Professional Service Representative, Lakeside Laboratories, Inc., 2705 Forty-ninth Street, Des Moines 50310 (Telephone 515-279-5843).

* * *

Health education exhibits from the American Medical Association are being rotated through the new Des Moines Center of Science and Industry under the sponsorship of the Scanlon Medical Foundation/Iowa Medical Society. Each display remains in the Center's exhibit hall for approximately six weeks. The first two exhibits have concerned human hair and glands. The Center is located in Ashworth Park. It opened in October.

* * *

Three Iowa physicians have recently been named Fellows in the American College of Physicians. Michael E. Korns, M.D., and Allyn L. Mark, M.D., both of Iowa City, and Joseph Song, M.D., Des Moines, have been so designated. Daniel B. Toubes, M.D., Iowa City, has been granted membership in the 54-year-old medical specialty society.

(Please turn to page 854)

STATE DEPARTMENT OF HEALTH

ARNOLD M. REEVE, M.D., M.P.H., COMMISSIONER

Drug Definitions

In the November JOURNAL the State Department of Health section was devoted to new state legislation which pertains to the treatment of persons addicted to or dependent on drugs. As an extension of this November discussion, you will find here the statutory definitions of (1) a narcotic drug, and (2) a depressant or stimulant drug.

Narcotic Drug

"Drug" as defined in Chapter 204.1 subsection 10 of the Code:

"Narcotic drug" means any of the following, alone, in combination, or mixed with other ingredients:

a. Opium, isonipecaine, cocoa leaves, or opiate.

b. Any compound, manufacture, salt, derivative, or preparation of opium, isonipecaine, cocoa leaves, or opiate.

c. "Marijuana" means all parts of the plant, cannabis sativa L., whether growing or not, the seeds thereof, the resin extracted from any part of such plant, and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds, or resin, but shall not include the mature stalks of such plant, fiber produced from such stalks, oil, or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks, except the resin extracted therefrom, fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination.

d. Any substance and any compound, manufacture, salt, derivative, or preparation thereof, whether produced directly or indirectly, by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, which is neither chemically nor physically distinguishable from any of the substances referred to in paragraphs "a," "b," or "c."

e. "Opiate" means any drug or other substance proclaimed to be a narcotic drug by rule or regulation of the board after reasonable notice and opportunity of hearing. "Opiate" means any drug or other substance and any compound, manufacture, salt, derivative, or preparation thereof which has been or may be found by the secretary of the treasury of the United States or his delegate, after due notice and opportunity for public hearing, to have an addiction-forming or addiction-sustaining liability similar to morphine or cocaine or to be capable of conversion into a drug having such addiction-forming or addiction-sustaining liability, where the relative technical simplicity and degree of yield of such conversion create a risk of improper use and proclaimed by the secretary or his delegate to have been so found in the federal register; but a drug or other substance shall cease to be an "opiate" for the purposes of this section if such finding is duly withdrawn by the secretary or his delegate.

Except that the words "narcotic drug" shall not include decocainized cocoa leaves or extracts of cocoa leaves, which extracts do not contain cocaine or ecogonine.

Depressant or Stimulant Drug

"Depressant or stimulant drug" as defined in chapter one hundred eighty-nine (189), section one (1), subsection six (6), Acts of the Sixty-second General Assembly.

"Depressant or stimulant drug" means any one of the following:

a. Any drug which contains any quantity of barbituric acid or any of the salts of barbituric acid; or any derivative of barbituric acid which has been designated under section 502(d) of the Federal Act as habit-forming.

b. Any drug which contains any quantity of amphetamine or any of its optical isomers; any salt of amphetamine or any salt of an optical isomer of amphetamine; or any substance designated by regulations promulgated under the Federal Act as habit forming because of its stimulant effect on the central nervous system.

c. Any drug, or other substance having a hallucinogenic effect, which contains any quantity of a substance designated by regulations promulgated under the Federal Act as having a potential for abuse because of its depressant or stimulant effect on the central nervous system.

Morbidity Report for Month of October 1970

Diseases	Oct. 1970	1970 to Date	1969 to Date	Most October Cases Reported From These Counties
Brucellosis	4	45	35	Dubuque
Chickenpox	316	4476	3777	Hancock, Jasper
Conjunctivitis	51	300	325	Carroll
Encephalitis				
California	1	2	3	Winneshiek
Echo 9	3	3	0	Dallas, Johnson, Mahaska
Echo 20	1	1	0	Winneshiek
type unspecified	1	2	4	Scott
German measles	20	2032	2324	Polk
Gonorrhea	657	4662	3643	Scattered
Histoplasmosis	3	17	16	Clarke, Jackson, Polk
Impetigo	180	552	524	Polk
Infectious hepatitis	26	301	334	Pottawattamie
Infectious mononucleosis	75	470	452	Johnson
Malaria, imported				
P. vivax	4*	20	14	Black Hawk, Iowa, Linn, Marshall
Measles	9	1116	338	Polk
Meningitis				
Coxsackie A4	1	1	0	Scott
Echo 9	3	3	2	Cerro Gordo, Polk, Worth
Meningococcal	1	12	19	Linn
Viral	3	8	6	Johnson, Polk, Pottawattamie
type unspecified	3	15	17	Audubon, Cerro Gordo, Pottawattamie
Mumps	278	2623	4145	Black Hawk, Polk
Pneumonia	99	769	404	Scott
Rabies in Animals	26	105	83	Des Moines, Keokuk
Rheumatic fever	6	48	30	Hancock
Salmonellosis				
S. blockley	2	5	3	Black Hawk, Polk
S. enteritidis	131	136	1	Woodbury
S. infantis	1	5	1	Dallas
S. oranienburg	2	4	1	Johnson
S. saint paul	1	3	5	Polk
S. typhimurium	7	27	31	Jackson
Shigellosis				
S. flexneri	5	9	3	Polk
S. sonnei	13	73	84	Dubuque
Streptococcal infections	62	5563	3760	Johnson
Syphilis	37	434	614	Scattered
Trichinosis	1	2	0	Black Hawk
Tuberculosis, active	13	113	99	Scattered
Whooping cough	3	20	13	Pottawattamie

*Delayed

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The Food and Drug Administration has requested that we bring to your attention a recent promotional campaign for Garamycin Injectable (gentamicin sulfate) which featured a nationwide *in-vitro* hospital survey involving a comparison of sensitivity patterns of Garamycin Injectable and seven other antibiotics.

The FDA considers the advertising misleading in several respects such as:

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus.* GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter.

Injectable Garamycin®

brand of gentamicin sulfate injection

Schering

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

BRIEF SUMMARY

INDICATIONS GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly Pseudomonas aeruginosa, Proteus and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

CONTRAINDICATIONS GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

WARNINGS Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

PRECAUTIONS In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentration of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

ADVERSE REACTIONS The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

PACKAGING GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

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Scientific Articles

Prevention of Urinary Infection In Patients With Indwelling Catheters

JOSEPH D. SCHMIDT, M.D.
Iowa City

AN ANALYTIC APPROACH to this subject assumes that the indwelling catheter is a necessity and that there is a real benefit to be accrued from prophylaxis in such a situation. Also, let us expand our pharmacologic umbrella to include anti-bacterials and sulfonamides in addition to antibiotics. And from the onset, let it be understood that such antimicrobial prophylaxis is *not* the *sine qua non* in prevention of urinary tract infection.

INDICATIONS FOR THE CATHETER

The more common problems which require the use of an indwelling catheter occur with patients whose measurement of urine flow rate is essential, e.g., trauma or other forms of shock; lower urinary tract obstruction or retention; and postoperative surgery, whether urological or nonurological. The question, Should a catheter be used at all? is to be answered in terms related to the patient's overall condition and not in terms of potential hazards. For there are few therapeutic modalities that do not offer side effects or disadvantages.

WHY USE ANY PROPHYLAXIS?

Why bother with any anti-microbial therapy? The answer relates to the well recognized role of the urinary tract foreign body in introducing or allowing infection to flourish. Studies have shown that nearly 100 per cent of patients with indwelling bladder catheters will have *bona fide* bacterial infections within 96 hours.[5] Since many patients requiring a catheter are already in a compromised state of health, a local urinary infection can more readily leap beyond its boundaries and spread to the upper urinary tract and become systemic. The bacteremia or septicemia that follows may be fatal early.[4, 15] The hypertension and chronic pyelonephritis that follow may be fatal later.[2, 7, 14]

These infections may stem from a patient's existing urinary infection, from contamination during the catheterization or of the equipment itself, or from the nearly inevitable exudate formed in the urethral lumen between the catheter and the urethral mucosa and glands.[9, 11, 13] Retrograde inoculation of bacteria from the collecting drainage tubes or reservoir is a very real hazard.[14] The patient's own gastrointestinal tract may be the locus.

Dr. Schmidt is an assistant professor in the Department of Urology at The U. of I. College of Medicine.

WHAT IS THE EVIDENCE?

Studies demonstrating the effects of prophylactic antimicrobial agents are clouded by variables in catheter care, many of which are discussed later. Kunin and McCormack reported a 77 per cent infection-free rate when a closed drainage system was used, but added that concomitant systemic antimicrobials seemed to decrease the infection rate.[8] Of those patients who did become infected, the average sterile interval was 11-14 days.

Using an open drainage system Martin and Brookrajian reported that the use of chloramphenicol or penicillin and streptomycin was as ineffective as no antimicrobial agent in preventing bacteriuria.[10] The use of a three-way catheter with bladder irrigations of either dilute acetic acid or neomycin-polymixin mixture was associated with a 20 and 0 per cent infection rate respectively. They felt that "chemotherapy merely shapes the character of the resultant bacteriuria." In a review by Levin, seven days of nitrofurantoin administration decreased the infection rate from 86 to 10 per cent.[9] He stated that "antibiotics are useless and often even dangerous when used prophylactically in patients with indwelling catheters. However, the short-term use of sulfonamides and other antibacterial agents that are not going to be used for treatment of systemic infection is indicated."

That urinary infection secondary to indwelling catheters could be reduced from 100 per cent to 10 per cent by various combinations of adjunctive measures was pointed out by Sanford.[14] He stated that "systemic administration of antibacterial agents . . . is unable to prevent the development of infection in patients with indwelling urethral catheters provided *other* measures are not instituted." Beeson felt the use of antibiotics in such situations eradicated the susceptible organisms but they created antibiotic-resistant infections.[3]

Noting the high rate of chronic pyelonephritis at autopsy, Kass stated that "prophylactic use of drugs in patients with inlying catheters is probably valueless and serves merely to convert the bacteriologic flora from susceptible to resistant to the prophylactic agent."[7] Butler and Kunin, emphasizing that prophylactic systemic antimicrobial therapy is ineffective when *open* urinary drainage is used, performed frequent monitoring of urine cultures.[4] A good response to specific systemic therapy was noted if *closed* drainage was employed. Forty-eight per cent of their patients were infection-free.

Ansell considered the closed drainage system essential.[1] With its use some patients had sterile urine for up to six weeks. Desautels recognized the futility of drugs in the absence of aseptic management of the catheter.[6]

So, from these studies, none of which are exactly comparable, a reasonable consensus is that neither systemic antibiotics nor antibacterials, used as the sole mode of prophylaxis, are effective in reducing urinary tract infection in patients with indwelling catheters. But the use of certain antimicrobial agents plus implementation of certain specific adjunctive measures can result in a real decrease in bacteriuria, and decreased bacteriuria will lead to less bacteremia and chronic urinary tract infection.

ADJUNCTS TO ANTIMICROBIALS

As important as any drug agent, and a subject of less debate, is the use of various adjuncts to reduce, if not prevent, entry of bacteria. For example, the use of the closed drainage system to eliminate the hazards inherent in the open drainage system has been well documented.[1, 4, 8, 11–14] The addition of disinfectants, e.g., carbolic acid, formalin and chlorhexidine, to the drainage reservoir may be of value.[1, 11, 13, 14]

Adequate fluid intake to dilute bacteria, as well as to increase the effects of antibacterials active mainly in urine, needs emphasis. Acidification of the urine with ascorbic acid (2-6 grams daily in divided doses) or methionine is often effective in prevention or control of infection when use in conjunction with antimicrobial therapy.[12] The use of nitrofurantoin, nalidixic acid and methenamine mandelate, in a consistently acid milieu, will either prevent the emergence of strains resistant to more potent drugs or sterilize the urine.

The characteristics of the indwelling catheter itself are worthy of mention. Its size should be large enough to drain adequately, yet small enough to keep urethral irritation at a minimum. Periodic catheter changes, whether weekly or monthly, are indicated in given situations. The use of silastic (medical grade sili-



Figure 1. Sterile transcatheter needle aspiration technique to obtain urine specimen for culture.

cone) catheters should help reduce both the local urethritis and the need for frequent changing.

Catheter care will contribute to reduction of bacterial entry plus surveillance of infection. Monitoring weekly (or more frequently, depending on the patient's condition) of urinalysis and urine culture should be performed by sterile transcatheter needle aspiration (see Figure 1), rather than by disconnection of the drainage system.[4] Variable results have been reported with the use of local antibiotics or chemical ointments and solutions to the external urethral meatus.[6, 11, 13] Certainly such treatment is indicated in those patients with considerable urethral exudate. Many patients can be instructed to cleanse daily the exudate from the catheter with hydrogen peroxide. For reasons both mechanical and pharmacologic, continuous and intermittent antibiotic irrigations of the catheter and bladder are not efficacious except in unusual circumstances.[10, 14]

CHOICE OF DRUGS

For preventive use, antibiotics, antibacterials and sulfonamides are available. Antibiotics are a poor choice because of the relatively rapid emergence of resistant strains incurred in their use. Also these agents can better be reserved for acute episodes of urinary infection, whether pyelonephritis or bacteremia. The decision to use one of the agents shown in Table 1 will be dictated by knowledge of the patient's aller-

TABLE 1

Antibacterials	Adult Dose*	Optimal Urine pH	Side Effects
Nitrofurantoin (Furadantin®)	100 mg. qid p.c.	Acid	G.I. upset, rash, peripheral neuropathy, pneumonitis, hemolytic anemia, fever.
(Macrodantin®)	100 mg. qid p.c.	Acid	As above but better tolerated.
Methenamine Mandelate (Mandelamine®)	1 gm. qid	Acid	G.I. upset, rash.
Methenamine Hippurate (Hiprex®)	1 gm. bid	Acid	G.I. upset, rash.
Nalidixic Acid (NeGram®)	0.5-1.0 gm qid	Entire Range	G.I. upset, hemolytic anemia.
Sulfonamides			
Short-Acting: Sulfisoxazole (Gantrisin®)	1.0 gm qid	Entire Range**	G.I. upset, rash, hematuria, fever, blood dyscrasia, urticaria.
Intermediate-Acting Sulfamethoxazole (Gantanol®)	1.0 gm bid	Entire Range**	As above.
Long-Acting Not Recommended	—	—	—

* In impaired renal function each of these agents must be used with caution and with appropriate reduction in dose.
** Sulfonamides more soluble in alkaline media.

gies, if any, his renal function and the agent's side effects.

FOLLOWUP OF THE PATIENT SO MANAGED

The patient with a normal urinary tract is able to rid himself of a urinary tract infection secondary to catheter drainage within several days; perhaps even faster if he is continued on the same prophylactic agent.[5] Even in the absence of localizing symptoms, a urine culture should be obtained three to five days after discontinuance of the drug agent. Any *bona fide* infection extant should be treated per sensitivity testing for a minimum of 14 days.

Patients with diseased or recently operated urinary tracts often demonstrate positive cultures in the catheter-free period. Continuance of the prophylactic agent for up to four to six weeks may be indicated until healing processes have restored the urothelial surfaces. Failure to clear such an infection after a reasonable length of time will indicate further or new urologic investigations. The efficacy of long-term antibacterial therapy in this category of patients is far from settled; at best only 20 to 30 per cent of such patients can be "cured."[14]

Intermittent catheterizations as an alternative to indwelling catheter drainage should be mentioned only for completeness. Such a method involves many extra man hours of nursing and paramedical help and drastically increases the chance of contamination.

CONCLUSIONS

Indications for the use of and the results of prophylactic antimicrobials with indwelling catheters can be best understood *only* in the *whole spectrum* of what we, as physicians, can do for the prevention and elimination of urinary tract bacterial infections. Antimicrobial coverage is no more important than our patient selection, attention to technics of instrumentation, use of a closed drainage system, good catheter care, periodic monitoring of the urine culture, and followup after the catheter has been removed. All our efforts should be directed to the manifold approach to prevent chronic urinary infection and sepsis in patients requiring an indwelling catheter.

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Tuberculous Peritonitis: Use of the Hook Needle Biopsy

DAVID F. GORDON, M.D.
Des Moines

The diagnosis of tuberculous peritonitis is often extremely difficult, especially in patients with Laennec's cirrhosis.[1-5] The series of 47 cases reported by Burack and Hollister[5] included 20 patients with associated Laennec's cirrhosis. The diagnosis was made in 16 of 27 cases (59 per cent) without cirrhosis, but in only 6 cases (30 per cent) of those patients with hepatic cirrhosis. Three alcoholics (15 per cent) were suspected of TB peritonitis and 11 (55 per cent) were not.

In this series fever was present in every case and abdominal pain and tenderness occurred in a significant number of patients. No sign or symptom could be considered diagnostic of tuberculous peritonitis and in many instances other diagnoses seemed well founded. In many cases there was no clinical or laboratory evidence of pulmonary tuberculosis. The sputum of 8 of 23 patients contained acid fast bacteria when cultured. Studies of ascitic fluid were clearly of "limited value."

Several other investigators have emphasized the difficulty in securing bacteriological confirmation in tuberculous peritonitis.[3, 4, 5] In the Burack and Hollister series[5] no acid fast bacilli could be demonstrated on smears of ascitic fluid, whereas slightly less than 50 per cent of cultures were positive for mycobacteria. A somewhat higher percentage (72 per cent) yielded positive returns when inoculated into guinea pigs. Thus, the ascitic fluid in tuberculous peritonitis may be "physically, chemically, microscopically, and bacteriologically, within normal limits,"[5] and exploratory laparotomy has been frequently the only means to a definitive diagnosis.

In 1958 Cope[6] reported the development of a hooked blunt-tipped needle for biopsy of the pleura, peritoneum, pericardium and synovium. A subsequent report[7] described the use of this instrument "in over 200 patients without any mortality or significant morbidity." Four cases of tuberculous peritonitis were found by such hook-needle biopsy.

The author has had occasion to employ a hook needle biopsy of the peritoneum in a patient with hepatic cirrhosis and protracted fever. From this experience it is possible to corroborate Cope's conclusion that it is a safe, simple way to diagnose tuberculous peritonitis.

CASE REPORT

W. H., a 49-year-old Negro man, a truck driver, was admitted to the hospital because of increasing abdominal girth. One month prior to admission he noted the gradual onset of anorexia, nausea, and increasing size of the abdomen. Easy fatigue, weakness and a 20-pound weight loss were also noted.

The patient was born in South Carolina, and had lived in New York State since 1930. His father died of tuberculosis in 1953. During the 25 years preceding hospital entry he had consumed alcoholic beverages in excess.

Physical examination revealed an alert, well oriented, thin, chronically ill appearing man, in no acute distress. Blood pressure was 126 systolic and 90 diastolic, pulse rate was 112 and respirations were 24. Oral temperature was 100.6 F. The skin was warm and dry. Scattered inspiratory rhonchi were heard over both lung fields. The abdomen had a firm sensation to palpation and a fluid wave was present. The liver was palpable 2 cm. below the right costal margin.

The urine gave a 2 plus test for protein; the sediment contained 30-40 white cells per high power field. Five cultures of urine for pyogens were negative. The hematocrit was 38 per cent; the white cell count was 5,800 with 76 per cent neutrophils, 4 per cent band forms, 19 per cent lymphocytes and 1 per cent

Dr. Gordon is in the private practice of cardiology in Des Moines.

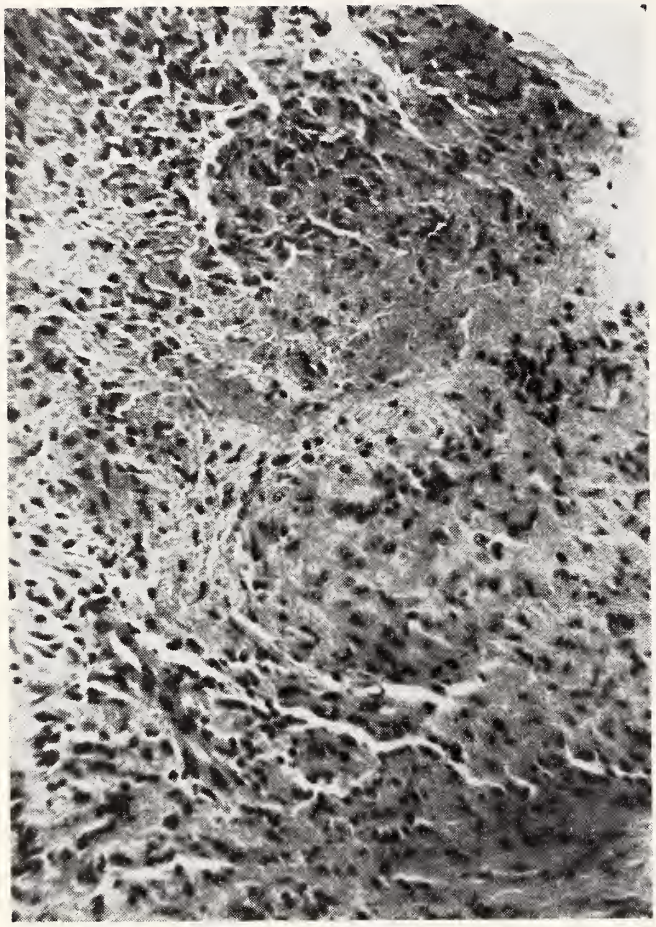


Figure 1. A photomicrograph of the peritoneal biopsy showing a granulomatous reaction with caseation necrosis.

eosinophils. The urea nitrogen was 15 mg., the creatinine 1.3 mg., and the bilirubin 0.45 mg. total per 100 ml. The prothrombin time was 13 seconds. The SGOT was 12 units, the alkaline phosphatase 5.3 KAU, the thymol turbidity 3.1 units, and the cephalin flocculation was negative. The protein was 7.0 gm. (The albumin was 3.4 gm., and the globulin was 3.6 gm.) The BSP revealed 10.5 per cent retention of the dye at 45 minutes. Three 72-hour sputum cultures for AFB were negative. A sickle cell preparation was negative. Guaiac tests for occult blood in stools were negative. X-ray films of the chest were negative. Excretory urogram revealed an indistinct calyceal system bilaterally with some puddling of the contrast medium within the right renal medulla. The gastro-intestinal series revealed some constriction of several loops of small bowel; the ileo-cecal junction was not well visualized.

The patient's course in the hospital was characterized by a remittent fever with daily temperature spikes to 104 degrees Fahrenheit. There was an additional weight loss of 21 pounds in 20 days and complaints of weakness and lethargy continued. A paracentesis and hook needle biopsy of the peritoneum was done. The ascitic fluid had the characteristics of an exudate, with a protein content of 5.8 gm. per cent. Microscopic examination of the fluid revealed 800 WBCs, with 99 per cent lymphs and 1 per cent polys. Culture for pyogenic organisms and acid fast bacilli of the ascitic fluid were negative. The peritoneal biopsy revealed bits of fibrous tissue heavily infiltrated by plasma cells and lymphocytes, containing two nodules of epithelioid cells with a caseous, necrotic center. One multinucleated giant cell was noted. The diagnosis was tuberculosis of the peritoneum. A Ziehl-Neelsen stain of the biopsy specimen revealed acid fast bacilli. PAS and INH therapy was instituted with a prompt remission in clinical findings. A subsequent sputum culture was positive for AFB.

CONCLUSIONS

This case augments the lesson already learned in other reports,[7] that the hook needle for biopsy in patients suspected of tuberculous peritonitis is worthy of wider use. It might be advisable to consider this approach in any patient with cirrhosis and unexplained fever, with or without ascites. The procedure is simple, appears to be relatively safe, and results are obtained promptly in a fairly high percentage of cases.[7]

The needle biopsy appears to avoid the need for laparotomy for diagnosis in most cases of tuberculous peritonitis. A heightened degree of suspicion and wider use of the hook needle biopsy may salvage many cases of tuberculous peritonitis.

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Porphyria: The Little Mimic
An Interesting Case With a General Review

CARL W. WHITE, M.D.
STEPHEN P. NICKNISH, M.D.
Iowa City

PORPHYRIA, LONG NOTORIOUS for its ability to masquerade, mimic and even entirely elude clinicians, can now be considered a royal malady.[1] For many years King George III of England was considered by medical historians to have been afflicted with a manic-depressive psychosis. The King had five major attacks of a medical and psychiatric illness, the first occurring when he was 26. These attacks were characterized by abdominal pain, constipation, severe weakness and stiffness, flushing and sweating, oliguria or at times polyuria, and symptoms of encephalopathy. Interestingly, throughout this long and severe illness, periods of complete remission would occur.

Perhaps the diagnosis of porphyria seems likely from this triad of abdominal symptoms, polyneuritis and mental disturbances. However, the 18th century physicians attending the King were quite perplexed. The commonest mis-diagnoses of porphyria today were considered in the King's case—biliary colic for abdominal pain, rheumatism for neuropathy and psychosis for encephalopathy.

Since porphyria is usually transmitted as a Mendelian dominant we would suspect other members of the royal family to have been affected. The King's youngest sister, Caroline Matilda, the banished queen of Norway and Denmark, succumbed within one week in her 24th year to a mysterious afebrile illness beginning with malaise, and followed rapidly by paralysis of her legs, arms and bulbar centers. Since no explanation of this death was available, it was assumed she had been paralyzed by poison. Such was probably not the case.

To a doctor concerned with disease and its cure there is no essential difference whether it affects a King or a commoner. We were recently presented with the interesting case of a commoner whose story is similar to these two monarchs. In our first appraisal of the patient we were as perplexed as the 18th century physicians, and after diagnosis our treatment efforts, though more sophisticated, were no more precise.

CASE HISTORY

D.D. was a 56-year-old, white female housewife from Clinton, Iowa. Her first admission to the SUIH (State University of Iowa Hospitals) was in 1959 for eight days, 30 days after a routine abdominal hysterectomy. She had persistent hyponatremia and asthenia post-op and was referred to SUIH for an Addisonian workup. All results, including 25 hour 17-OH and 17-Keto steroids, were inconclusive and she recovered to good health spontaneously.

Her second admission to SUIH was in December, 1968. On October 10, 1968, she underwent a routine cholecystectomy for a six-day history of colicky RUQ pain. She was discharged October 15 without complications. Two days later she developed nausea, vomiting and belt-like lower abdominal pain which was paroxysmal and worse post cibum. She was readmitted to her local hospital and treated with nasogastric suction and Cortisone 15 mg. daily for low Na+ and K+. She was discharged again November 5 and readmitted two days later for nausea, vomiting and the same lower abdominal pain. She was again treated with Cortisone 15 mg. and I.V. fluids. During this hospital stay she developed bilateral lower leg thrombophlebitis and was anticogulated with Coumadin.

She successfully progressed to soft foods by

Dr. White is a fellow in the Department of Internal Medicine at The U. of I. College of Medicine. Dr. Nicknish was an intern at the College of Medicine at the time this article was prepared.

mouth and her abdominal pain markedly diminished in four weeks of hospitalization. However, her hyponatremia, hypocholoremia, asthenia and now orthostatic hypotension persisted. Therefore, it was decided to transfer her to SUIH on December 6. The day before her transfer she received three liters of fluids and several cathartics for constipation.

Past History: Past history includes syphilis at age 18 and mild hypertension over the past several years.

Physical examination on admission: BP 150/90 supine, no change sitting, 0/0 standing. Pulse 120/min. and regular. She appeared as a well nourished, well developed, white female with generalized increased skin pigment. Positive findings included a fine hand and tongue tremor, a right thyroid nodule, a tympanic abdomen with rebound, right and left upper quadrant tenderness, hypoactive bowel sounds, generalized asthenia but mobility in all extremities and decreased DTR's at the knees and ankles.

Lab data on admission: Normal BUN, creatine, Hct, WBC and blood sugar. Na+ 127, K+ 4.0, Cl 75, CO_2 30, Alk. phos. 3.2, SGOT 32, bilirubin .2/.6, T_3 34.8%, T_4 15 mcg., I^{131} 5% at 4 hrs. and 17% at 24 hrs. Urine S.G. 1.006 (or osmolarity of about 200), serum osmolarity 258.

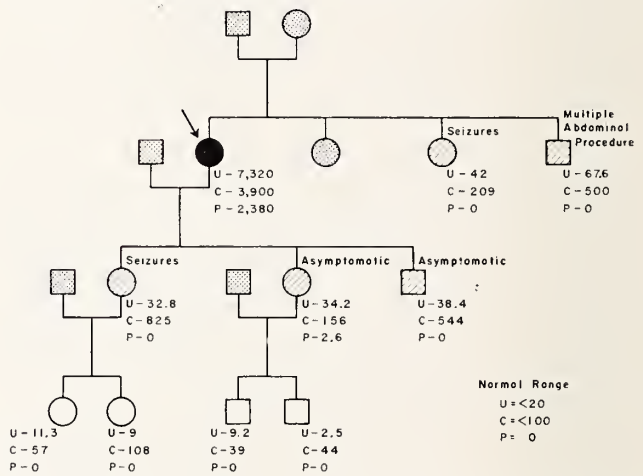
Hospital course: Her hyponatremia and hypochloremia were confirmed by our laboratories and persisted despite a high urine output. Over the next four days she developed progressive ascending paralysis, progressive loss of lower extremity sensation and increased somnolence with the correction of her electrolytes towards normal. Treatment consisted of one dose of dexamethasone, 9 alphafluorohydrocortisone and prophylactic heparin anticoagulation. No barbiturates were given during this hospital course and during the latter part of her local hospitalization. Four days after admission a Watson-Schwartz test with spectrophotometer confirmation was positive.

Special laboratory tests: 24 hr. ketosteroids 3.7 and 6.7 mg., 24 170H 21.9 and 13.5 mg., uroporphyrins 7320 mcg/TV (nl 20), coproporphyrins 3900 mcg/TV (nl 25-100), porphobilinogen 2380 mcg/24 hrs. (nl 0/day). Two days later she developed respiratory distress, secondary to an ascending paralysis, resulting in a po_2 of 39. She was transferred to the ICU where a tracheotomy and a prophylactic feeding gastrostomy were performed. Though her electrolyte imbalance was corrected and porphyrins returned to normal her quadraplegia and respiratory paralysis persisted and after four weeks of assisted ventilation she developed the complications of bedfastness and tracheostomy; namely a tension pneumothorax and staphylococcus pneumonia. She died January 7. No autopsy was granted.

Interviews with the family and urinary porphyrin determinations revealed a striking familial correlation of symptomatology and abnormal porphyrin excretion. (Table 1).

TABLE I

FAMILIAL INCIDENCE OF PORPHYRIA (D.D.)



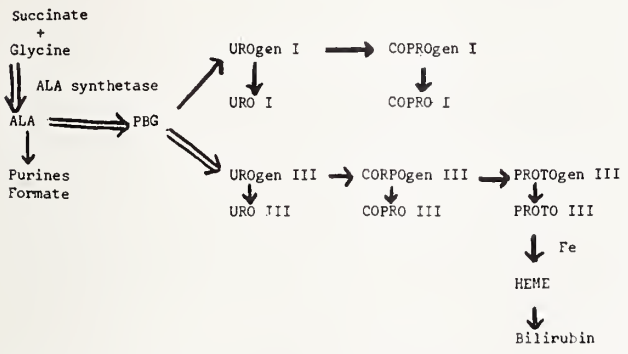
BIOCHEMISTRY

Prior to 1946, little was known about the chemical building blocks of porphyrins and heme. The widely accepted but erroneous belief was that urinary porphyrins were derived from the breakdown of hemoglobin. We now know that ALA (delta-amino-levulinic acid) and PBG (porphobilinogen) are obligatory intermediates in the biosynthesis of porphyrins, and that porphyrins themselves are intermediates in the metabolic pathway for the production of hemoglobin.[2] (Table 2)

Glycine and succinate combine to form ALA. This reaction is under the control of the enzyme ALA synthetase. The overproduction of this enzyme has recently been incriminated in the pathogenesis of the increased amounts of porphyrin precursors found in this disease. Thus in our present state of knowledge, por-

TABLE 2

BIOSYNTHESIS OF HEME



phyria does not appear to be an enzyme deficiency disease, but rather one of increased enzymatic synthesis.[3] Porphyria differs from other metabolic diseases (such as galactosuria and PKU) in that the intermediate metabolic products which accumulate in excess amounts are not, in themselves, toxic to the host.[4] PBG and ALA given experimentally in large amounts to normals do not cause symptoms of an acute attack, and correspondingly, reduction of the levels of PBG and ALA during an acute attack does not ameliorate the toxic effects. (It should be noted that in this case, the excretion pattern of porphyrin precursors in no way correlated with the clinical course.) (Table 3)

Although all aerobic cells can synthesize heme, its formation is particularly active in the erythroid elements of the bone marrow and liver. The small quantities of uro- and coproporphyrins normally found in the urine and bile are derived from these sources. This distinction in site of formation has served as a convenient classification of the porphyrias. (Table 4)

This patient represents a case of hepatic

TABLE 3

CLASSIFICATION

A. HEPATIC PORPHYRIA
 1. Acute intermittent (Swedish)
 2. Variegate (mixed) (South African)
 3. Cutaneous (porphyria cutanea tarda)
 a. Hereditary
 b. Acquired

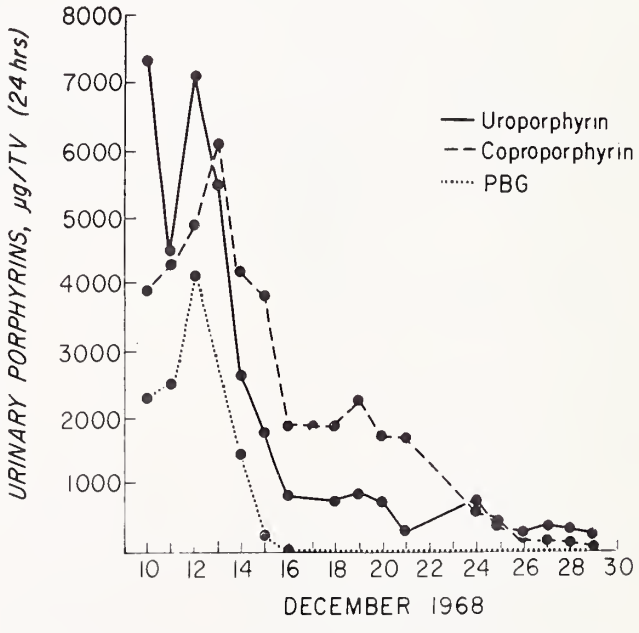
B. ERYTHROPOIETIC PORPHYRIA
 1. Congenital
 2. Erythropoietic protoporphyria

porphyria, so the erythropoietic varieties will be commented upon only very briefly. These are extremely rare diseases. In congenital erythropoietic porphyria, the urine contains large amounts of uroporphyrin I and coproporphyrin I, but the excretion of ALA and PBG are normal. This is an autosomal recessive trait, with only about 60 cases reported in the world's literature. It is characterized by chronic photosensitivity and a hemolytic anemia. These patients have increased facial hair, fluorescent bright red teeth and excrete a characteristically pinkish urine.

The other form of erythropoietic porphyria,

TABLE 4

URINARY PORPHYRIN EXCRETION (D.D.)



recently recognized, is characterized by the finding of high concentrations of protoporphyrin in RBC's and feces, and is associated with a solar urticaria or eczema, but not the abnormal mechanical fragility seen in the other forms of photosensitive hepatic porphyria.[5]

In the hepatic porphyrias—as the name implies, the abnormal porphyrins are produced by the liver. The subdivisions of this variety are more complex because there is some overlap in the biochemical and clinical characteristics.

Acute Intermittent Porphyria (Swedish) is an autosomal dominant disease characterized by attacks of abdominal pain, neurological

When irritable colon feels like this



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manifestations and often simulates endocrinologic disease.[6] This is the only type of porphyria in which photocutaneous manifestations are absent. Acute attacks are rare before puberty and most often begin in the third or fourth decades. The urinary excretions of PBG and ALA are greatly increased during acute attacks, and usually remain increased during quiescence. Usually there is no increase in urinary or fecal copro- or uroporphyrins, though there may be, especially in acute attacks.

I. Abdominal pain, often colicky, moderate to severe is the most frequent symptom. It is often severe enough to simulate an acute surgical abdomen—and is frequently misdiagnosed as cholelithiasis, renal colic, peptic ulcer, appendicitis, bowel obstruction, or pancreatitis. It has been stated that rebound tenderness is not seen; however, in this patient it was a prominent finding. This type of porphyria should figure prominently in the differential diagnosis of bizarre abdominal pain, and of the acute surgical abdomen when the signs and symptoms of other recognized disease entities are conflicting. Persistent constipation is usually present and diarrhea usually absent. Prolonged vomiting may occur, and may be accompanied by a classic picture of adynamic ileus.

II. The neurological manifestations are extremely variable, and may range from isolated muscular weakness, or a distinct peripheral neuropathy, to a fulminant ascending paralysis (Guillain-Barre), with flaccid paralysis progressing to bulbar involvement and respiratory paralysis as was seen in this case. It is likely that most of the clinical manifestations of this disease result from involvement of peripheral nerves. Psychiatric symptoms are often present in variable degree from mild neurosis to severe manic-depressive psychosis.[7]

III. Addison's disease and thyrotoxicosis may be easily confused with porphyria. The syndrome of inappropriate ADH secretion is not uncommonly produced by this disease.[8]

Variegate Porphyria (South African, Mixed) is also an autosomal dominant disease, quite prevalent among the white inhabitants of South Africa, where the incidence is about 3/1000. Much interesting genealogical work has been done in this disease and it appears that the thousands of people who have inherited porphyria are one huge family, direct descendants of Gerrit Jansz, one of the first free burghers of Capetown, who emigrated from Holland in 1687. From this work it appears that until recently porphyria was not a deleterious gene, because the porphyric families seemed to have the same number of children (12-16) as other families. It was not until the advent of modern medicine (with the synthesis of drugs which act as precipitating factors) that the deleterious effects of this gene became apparent. Variegate porphyria is of more than local or historical interest in that many of these early porphyrics were trek Boers, whose descendants emigrated overseas so that this condition is now found in Western Europe and the United States.[9]

The symptoms of this disease are very similar to acute intermittent porphyria—neurological and abdominal disturbances, but in almost all cases, cutaneous photosensitivity is present. Increased amounts of ALA and PBG are present in the urine during acute attacks only and not during convalescence, but here, increased amounts of copro- and uroporphyrins are found in remission, and in latent cases, as well as in acute attacks.

The third form of hepatic porphyria, porphyria cutanea tarda, affects mainly the skin, with involvement manifested by increased mechanical fragility and photosensitivity. This is most frequent in males from the fourth to sixth decade, and is extremely common in the Bantus of Africa. As many as 50 per cent of the Bantus in some areas suffer from this disease. There is usually an association with chronic alcoholism, and hepatomegaly is common. These patients notice that after a bout of heavy drinking their urine becomes dark, and their skin becomes unduly sensitive with blistering occurring on exposed areas. Urinary ALA and PBG are usually normal, but urinary uro- and coproporphyrin are greatly increased.

DIAGNOSIS

The simplest diagnostic test to perform is the Watson-Schwartz test, a medical classic which is easily performed by the smallest hospital laboratory, or at the bedside. This is a test for the presence of porphobilinogen, and is therefore positive only in the AIP and Variegate varieties. Porphobilinogen in the urine reacts with Ehrlich's aldehyde reagent (p dimethylaminobenzaldehyde) to form a bright

pink or red color, which is not extractable with butanol. Copro- and uroporphyrin form colorless compounds with this reagent so yield negative tests. The magnitude of PBG present, especially during conditions of remission may not be sufficient to give a positive test, and therefore other more complicated methods must be used.

Quantitative chemical determinations of ALA, PBG, copro- and uroporphyrin can now be obtained at many larger hospital or commercial laboratories, and the diagnosis confirmed and exact type classified with this information. False negative and false positive Watson-Schwartz tests do occur, and therefore the definitive diagnosis of porphyria should not be made on this basis alone.

The diagnosis of hepatic porphyria is strongly suggested when routine urine passed by the patient turns dark upon standing. This is due to the oxidation of the porphyrin precursors to porphobilin, a brown pigment.

One of the most interesting features of porphyria is the well known observation that certain drugs precipitate acute exacerbations. The two most notorious offending agents are barbiturates and sulfonamides, but griseofulvin, estrogens (oral contraceptives), chloroquine and alcohol have also been incriminated. Classically the porphyric presents with an acute abdomen, whose symptoms are greatly exacerbated by sodium thiopental anesthesia, or the symptoms may occur postoperatively secondary to the use of barbiturate sedation. Such occurrences are often fatal. It has been difficult to make any rhyme or reason out of the list of precipitating drugs. It appears that for some reason these drugs are able to induce ALA synthetase production, which is the rate-limiting enzyme in porphyrin production.[10]

There is no specific therapy for porphyria, so the treatment remains symptomatic and prophylactic. The pain and psychiatric manifestations are best controlled by thorazine, reserpine, or meperidine. There is no evidence that these agents alter the course of the acute attack. Ganglionic blocking agents have been tried for the relief of abdominal symptoms but must be used with caution because of the potential for the development of hypotension. Supportive treatment is of utmost importance. The often accompanying dehydration and hyponatremia should be corrected, and respiratory support is essential if the paralysis involves bulbar centers.

The most important therapeutic principle is to avoid precipitation by drugs and known offending agents. Barbiturates should not be used for sedation or anesthesia in such patients, and sulfonamides should be scrupulously avoided.

The prognosis seems to be fair, with about 25 per cent mortality in the acute attacks. It is possible to survive severe acute attacks, even with respiratory paralysis and coma in some cases. Vitamin B-6[11] high carbohydrate diet[12] with or without insulin[13] have been recently advocated for treatment, but the results from this are not conclusive. Hemodialysis has been found of little benefit.

SUMMARY

Porphyria is not an uncommon disease and the diagnosis, once considered, is not a difficult one. We must not allow this "little mimic" to continue to escape detection; for it is only through diagnosis that understanding of the mechanisms involved can progress and lead to improved treatment.

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University Hospitals DRUG LETTER

Rubella Vaccines

ALFRED HEALY, M.D.
Iowa City

The Public Health Service Advisory Committee on Immunization Practices, in close cooperation with the Committee on the Control of Infectious Diseases, American Academy of Pediatrics, published recommendations for the use of rubella vaccines (AJDC, Vol. 118, 1969). Since that statement, further evidence has accumulated and was presented (7th Annual Immunization Conference, National Communicable Disease Center) to substantiate the initial recommendations.

Rubella is usually a mild disease in childhood, but when infection is acquired by a pregnant woman during the first months of pregnancy, it is capable of causing serious congenital malformations of the fetus. Some of the malformations, such as deafness, are not recognizable at the time of birth. Most studies indicate that 80-90 per cent of young adults have contacted the disease during childhood and have protective levels of HI antibodies. This leaves approximately 10 per cent of the women of childbearing age seronegative for rubella, and therefore susceptible during the time of a naturally occurring epidemic. Of the 10 per cent seronegative women of childbearing age, one of 10 contacted the disease and delivered an affected child during the last epidemic in 1964-1965 (1 per cent of all live births). Iowa's live birth rate is approximately 45,000 per year. It is estimated the total cost of special education-rehabilitation and medical services per child is $73,250.

At the present time hemagglutination-inhibiting (HI) antibody determination is the most practical and widely used determination of immunity.

Three licensed vaccination materials are now available from four companies (Philips Roxane, Parke-Davis, Merck, and Smith Kline & French), and have been proven in clinical trials to be effective agents for the production of protective (HI) antibody titers. The Philips Roxane and Parke-Davis vaccines are prepared from the HPV-77 virus cultured on dog kidney tissue, the Merck vaccine is prepared from the HPV-77 virus cultured on duck embryo tissue, and the Smith Kline & French vaccine is prepared from the Cendehill strain cultivated on rabbit kidney tissue. Differences exist between the vaccines, although all have been judged to be acceptable. Differences include: 1) the number of seroconverters following immunization; 2) the mean geometric levels of antibody (HI) attained following immunizations; and 3) the incidence of side effects. Mean geometric levels of antibody are difficult to compare because of individual laboratory interpretations of titer determinations.

The side effects of rubella immunization include arthralgia, lymphadenopathy, arthritis, and hypersensitization to the materials used in the preparation of the individual vaccine (dog kidney, duck embryo, or rabbit kidney). Neomycin is used in the manufacturing process, and vaccination of a person known to be hypersensitive to neomycin should be avoided. Arthralgia is found mostly in adult females, but also occurs in children. It has been noted 8-35 days following immunization and may last from a few days to three weeks. The severity of arthralgia has ranged from transient minor aches to significant pain in the fingers, hands and large joints. Objective signs of arthritis have been rare.

Current recommendations for immunization are:

a) *Children between the ages of one year and puberty should be immunized.* Vaccination prior to one year of age is not recommended, due to the possible interference of maternal antibody. Children in the early elementary grades should receive priority. A history of rubella infection in the past is usually not an indication to avoid rubella immunization. In no sense is the disease communicable following immunization.

b) *Routine immunization of women in the childbearing years should be avoided.* However, if a post-pubescent female is found to be seronegative, and an acceptable pregnancy test is negative, vaccination can be administered, provided a medically acceptable means is utilized to prevent conception for two to three months following vaccination.

Two programs to immunize women in the childbearing years are possible.

1) Immunity may be routinely determined by HI testing at the time of marriage. If immune, the woman should be assured she is not in need of immunization. If susceptible, and if a pregnancy test is negative, she should be vaccinated if conception is avoided for two to three months.

2) Immunity may be routinely determined in the prenatal period, with immunization in the post-partum period if needed. Methods to prevent conception would also need to be utilized for two to three months following vaccination.

c) *Pregnant women should not be vaccinated.* The effect of vaccination upon the fetus in a woman immunized during pregnancy has not yet been fully determined. However, 23 women to date have been vaccinated prior to anticipated

(Please turn to page 835)



Editorials

AT CHRISTMAS AND BEYOND

Those in the office of the Iowa Medical Society and those associated with the JOURNAL wish you and yours a Merry Christmas and in so doing express a profound hope for *Peace on Earth, Good Will Towards Men.*

It is a fitting time for peoples of all nations, of all colors, of all creeds to embrace and to practice the philosophy of "do unto others as you would have others do unto you." Surely mankind can resolve differences without recourse to war and threats of war, and live together harmoniously without hate, violence and terrorism.

May Peace, Justice, Equality and Love of God prevail throughout the world and bring joy and hope to all mankind.

EARLY DISCHARGE OF SURGICAL PATIENTS

The benefits of early ambulation following surgery are well recognized and it has become a common practice following most operative procedures. A more recent innovation is the early postoperative discharge of patients from the hospital. A recent report by Paul T. Lahti, M.D.,* senior attending surgeon, William Beaumont Hospital, Royal Oak, Michigan, presents a somewhat startling review of a large number of surgical patients discharged from the hospital much earlier than is the custom in the vast majority of hospitals. Among 1,114 consecutive surgical patients, 75 per cent went home on or before the second postoperative day.

Included in the study were patients undergoing all procedures except gastric surgery, bowel resections, trauma and minor surgery. Obviously, these were all general surgical patients and did not include patients undergoing operative procedures in the surgical specialties.

In the whole group of 1,114 patients only four were readmitted to the hospital, two for three days and two for four days. The author asserts that in his experience early postoperative discharge is beneficial to the patient not only for financial reasons but for health reasons. It is also beneficial to the surgeon in time saved; to the hospital in better utilization of facilities, and to the insurance companies in lower rates. According to the author, since the acceptance of early ambulation of the surgical patient, there has been a gradual reduction in the period of hospitalization after surgery, and a realization that definite benefits result from this practice. It not only reduced the period of disability, it practically eliminated complications. Experience has taught that it is now possible and desirable to discharge the majority of patients on the first or second postoperative day.

In the study the author compares the dura-

* Lahti, Paul T.: Early postoperative discharge of patients. MICHIGAN MED., 69:755-760, 1970.

Editorials continued...

tion of postoperative stay with those of the Professional Activity Study (PAS) which recorded the average postoperative stay for the various procedures in 995 hospitals during periods from January, 1965, through June, 1968.

Among the 1,114 patients, 377 were operated for the correction of an inguinal hernia. Eighty per cent were discharged on or before the first postoperative day, compared to the (PAS) average postoperative stay of six days. In the group of 377 hernia patients, 152 were under 14 years of age, 143 had unilateral hernias and nine were bilateral. Thirty-four went home from the hospital on the day of the operation, 114 on the first postoperative day, three on the second and one on the fourth. In the group of 255 hernia patients, age 15 and over, three went home on the day of operation, 148 on the first postoperative day, 49 on the second, 13 on the third, and 13 patients remained in the hospital four or more days.

There were 142 appendectomy patients, among whom the appendix was gangrenous in 13, perforated in 10, and acutely inflamed in 119. Of these, 116 or 82 per cent went home on or before the second postoperative day. This contrasts with an average PAS hospital stay of six days for patients undergoing appendectomy. Six patients returned to their homes on the day of the operation, 83 went home on the first postoperative day, 28 on the second, eight on the third, and 17 on the fourth or later day. Among 43 patients with recurrent or incidental appendectomy, 70 per cent were discharged on or before the second postoperative day, and the remaining 30 per cent by the fourth day.

Sixty-nine patients underwent ligation and stripping of saphenous veins, 15 unilateral and 54 bilateral. Ninety-one per cent of this group of patients were discharged on or before the second postoperative day. This contrasts with an average hospital stay of five days according to the PAS survey.

There were 70 patients subjected to hemorrhoidectomy. Eight were discharged on the first postoperative day, 28 on the second, 14 on the third, and 20 on the fourth day. According to the PAS survey the average postoperative stay following hemorrhoidectomy was six days.

Surgical procedures for pilonidal cysts were done on 27 patients. Ninety-seven per cent were discharged on or before the second postoperative day, which contrasts with a PAS average stay of six days.

Breast tumors were excised in 142 patients, 129 were unilateral and 13 were bilateral. Ninety-eight per cent of these patients were discharged on or before the second postoperative day, the remaining two per cent on the fourth. The average PAS postoperative stay is three days.

Mastectomy was carried out in 24 patients, for six the procedure was a simple excision and in 18 it was radical. In this group of 24 patients, 34 per cent went home on or before the third postoperative day. The remaining 66 per cent were discharged from the fourth to the seventh day. The average stay in the PAS study was seven days for a simple mastectomy and 14 days for radical mastectomy.

Twenty-eight patients underwent thyroidectomy, 15 unilateral and 13 bilateral. In this group one patient went home on the day of operation, five on the first postoperative day, 12 on the second, five on the third, and five on the fourth day. Thus 64 per cent went home on or before the second postoperative day. The average PAS stay was six days.

Cholecystectomy or cholecystostomy was performed in 150 cases for an acute, subacute or chronic problem. Sixty-three (42 per cent) of those patients were discharged on or before the third postoperative day, and none of them were hospitalized longer than seven days. The average PAS postoperative stay was 10 days.

According to the author, the patient who knows he will be up and about the afternoon of surgery and home after a day or two is relaxed and unafraid, and requires little postoperative medication. This is in contrast to the usual patient entering the hospital for major surgery who is frightened of the unknown and following the operation every minor discom-

fort is magnified into real pain. Narcotics only prolong the recovery.

In this group of 1,114 patients, there were no deaths or complications, such as atelectasis, pneumonia, urinary retention, thrombophlebitis, or pulmonary embolism. Only four patients were readmitted to the hospital, none of them requiring more than four days of hospitalization.

To succeed Dr. Lahti declares such a program must have several elements:

1. The surgeon must believe in it himself.
2. Confidence in the procedure must be imparted to the patient preoperatively.
3. The patient must be encouraged to be up and around immediately on awakening from the anesthetic. By so doing most of the postoperative spasm and pain are relieved.
4. The nurses must be instructed concerning the avoidance of narcotics. Usually, for an adult, only one or two doses of 50 mg. of Demerol are sufficient.
5. The patient must be given a mild analgesic to relieve the normal amount of discomfort.
6. If a patient is reluctant to go home, it is important to convince him that as soon as the need for hospitalization is over, he is much better off at home. No patient is discharged against his wishes.

The author states that the method works. It is not in the experimental stage for it has been used on several thousand patients. In the usual case there is no need to keep a patient any longer than is necessary to recover from the anesthetic. Upon discharge, each adult is given a prescription for an analgesic, usually Darvon with acetylsalicylic acid, however most patients usually take only one or two. Dr. Lahti concludes, "It is difficult to overcome the traditions and habits of the past but the results are certainly worth the effort."

The fear that "something may go wrong if he goes home" is now changed to "something may go wrong if he stays in the hospital."

HIGH RISK OBSTETRIC PATIENT

A recent article by Cole* on the subject of cardiac disease in pregnancy emphasizes the potential hazards are so marked each such case should be considered a "high risk obstetric patient."

To understand the problem of cardiac disease in the gravid patient it is necessary to understand some of the physiological changes which occur in normal pregnancy. Dr. Cole emphasizes it is these physiologic changes which can convert a well compensated cardiac patient to decompensation during the period of her pregnancy.

Although there is some controversy over various factors which call for an increased cardiac output during pregnancy, it is quite generally accepted that the placenta constitutes a large arterial-venous shunt. Since approximately one-fourth of the cardiac output traverses this shunt, it is easily understood how a borderline compensated patient might get into serious difficulty. It is pointed out that this shunt reaches its maximum size at about the eighth month of pregnancy, and thereafter diminishes in size as the small vessels become obliterated during the final weeks of pregnancy. Thus the cardiac patient is prone to have problems from the increased load imposed by the placental shunt during the seventh and eighth months, rather than in the last few weeks of pregnancy.

A second important physiological factor which contributes to the hazard of the gravid cardiac patient is the marked increase in plasma volume. This is estimated to increase by 60 to 65 per cent, and results in an increase in cardiac work. The greatest plasma volume occurs at about the seventh month, after which there is a slow decline until term.

During a normal pregnancy total body water increases to a level approximately 20 per cent above normal, and like the increase in plasma volume, it contributes to the necessity for increased cardiac work.

A more obvious contribution to demands upon the heart is the work during labor and delivery. During this phase of pregnancy, work may be tremendously increased. Though the

* Cole, Byron K.: Cardiac disease in pregnancy. OHIO STATE MED. J., 66:924-926, 1970.

Editorials continued...

work required is intermittent, it reaches its peak during uterine contractions. It is emphasized that the total work done per minute may indeed be very great. Also the heart must continue to carry an additional load for an hour or more after the second stage of labor to compensate for the oxygen deficit which develops during labor.

Even following delivery certain physiological events occur which put an additional load upon the heart. Blood volume is increased due to extravasation of blood from the placenta to the general circulation. After removal of the placenta there is an increase in peripheral resistance which is in contrast to the usual reduction in peripheral resistance during pregnancy. It is also recognized that there is a greater venous return to the right side of the heart as a consequence of increased muscular contraction during labor.

The author cautions that there are certain signs and symptoms which occur during pregnancy which may lead one astray, ascribing them to congestive heart failure, when they have no real significance. Swelling of the ankles is common in women without heart disease. The enlarging uterus exerts some pressure on veins leading from the lower extremities, resulting in an increased venous pressure within them. However ankle edema frequently occurs before there is any significant increase in the size of the uterus. This is attributed to early hormonal changes which produce an increasing flow of blood to the developing fetus and uterus. The increased venous return from the pelvis to the inferior vena cava causes some impedance of flow from the extremities, resulting in increased venous pressure and a resulting edema.

Dyspnea is not an uncommon complaint of the pregnant woman, so that it must be interpreted with caution. The increased size and weight of the breasts may interfere with free breathing and the enlarging uterus and abdomen may cause some respiratory embarrassment.

The author emphasizes that the pregnant cardiac patient requires dedicated and skilled care by a cardiologist and an obstetrician, and that frequent observation is mandatory throughout the pregnancy. He states that the number of necessary visits of the patient is only equalled by the quality of care rendered by the team of physicians. The management of the gravid cardiac patient is based on the accurate diagnosis of the heart disease and its classification according to the New York Heart Association. Classes I and II need not be severely restricted but additional rest is indicated. Greater restrictions should be required by Class III patients, and hospitalization during the latter part of pregnancy is advisable for patients in Class IV.

The new diuretics are very helpful in the management of these patients. Sodium restriction is often unnecessary except in severe cardiac cases. The indications for the administration of digitalis are very much the same as they are for any cardiac patient. Ordinarily, it is not necessary unless there is some evidence of congestive failure. Prophylactic administration is clearly justified in some of the patients with the more serious cardiac problems.

It is urged that patients with rheumatic heart disease be given prophylactic antibiotics, and acute infections should be treated aggressively. It must be remembered that acute infection in a patient with rheumatic heart disease is often a causative factor in congestive heart failure.

The author points out that the first signs of congestive failure may occur during or after labor as a result of the tremendously increased work load. It must not be forgotten that congestive failure may occur at any time during pregnancy or shortly thereafter, and the patient should be under careful cardiac care for at least two weeks after delivery.

In regard to the delivery, it is generally accepted that cesarean section in gravid cardiac patients should be done only for obstetric reasons. The skillful application of low forceps may be indicated to shorten the second stage of labor.

With careful and skilled management it is usually very surprising how well the cardiac patient comes through the ordeal of pregnancy and labor.

American Association of Medical Assistants

State of Iowa, Inc.

We Did, Indeed, Reap a Harvest!

The last week of October was indeed a memorable one for Iowa Medical Assistants. There were so many things going on I find it difficult to put them in any order of importance—they were all important and all of interest!

First, we owe a big "thank you" to our General Chairman, Mrs. Marian Little, and our able Vice-Chairman, Mrs. Lucille Holmes. They worked long and hard to make the fourteenth AAMA Convention an outstanding one. All Iowa members did their part and the committee chairmen are to be congratulated for a job well done. Space prevents naming all but I would be remiss in not commending Mrs. Barbara Smith, who handled the Registration Desk so efficiently. I believe our guests will long remember the gracious hospitality found in the "Iowa Room," as well as the Welcome Committee, composed of our Chapter Presidents, which participated in the ribbon-cutting ceremony.

We were happy, too, to have my boss, Dr. James Bishop, Chairman of our Iowa Advisory Board, take time from his busy schedule to attend the Iowa party and take part in the Campaign Cornucopia. With all of the regular political campaigning going on that week, campaign excitement reigned double for AAMA members at the Campaign Cornucopia on Wednesday evening when all of the candidates for office were presented. Elected on Thursday were the following: President—Mrs. Marie Young, Indianapolis, Indiana; President-Elect—Mrs. Helen Stephens, Ogden, Utah; Vice-President—Miss Elisabeth (Betty) Massey, San Diego, California; Secretary-Treasurer—Mrs. Mary Bourzikas, St. Louis, Missouri; Speaker of the House—Mrs. Betty Lou Willey, Port Huron, Michigan, and Vice-Speaker of the House—Miss Marlouise Redman, Harper Woods, Michigan.



NATIONAL MEETING—Mrs. Jeanne D. Green, of Davenport, left, was elected to the Board of Trustees of the American Association of Medical Assistants at the recent national convention in Des Moines. Shown with Mrs. Green above is Colleen Proffitt, of Des Moines, president of the Iowa Chapter of AAMA.

Three Trustees are elected each year to three-year terms and those chosen in October were: Jeanne D. Green, Davenport, Iowa; Norma Whelchel, Lincoln, Nebraska, and Sarah McClure, Jacksonville, Florida.

When our State President, Colleen Proffitt, gave the official welcome on Friday, our Iowa girls were impressive in their dark dresses with pink banners and their wild rose hats, as they stood to represent the State of Iowa Chapter.

James H. Sammons, M.D., Baytown, Texas, AMA Trustee and Special Liaison to the AAMA Advisory Board, substituted at the Friday luncheon for AMA President Walter C. Bornemeier, M.D., and offered this greeting:

"It is a pleasure for me to extend greetings from the American Medical Association to the American Association of Medical Assistants and to offer the best wishes of the AMA's 220,000 members.

"It is the pressing need in this country for more and better health care that binds us so closely. The obvious urgent need today is a sharp expansion of the totality of medical and related services provided by physicians and other health professionals, in an efficient and productive team effort.

"The use of paramedical personnel to extend the hands of the physician is just beginning to receive adequate emphasis. At the present time there are about 14 allied health people for each physician—a convincing indication of the importance of the medical assistant. She is one of our most important resources. Together, the AMA and the AAMA must work to achieve utmost utilization of this valuable pool of talent."

Dr. Sammons lauded the AAMA for its 20 per cent of membership attendance at the convention; he said this was a remarkable accomplishment. He then announced an AMA grant of $15,000 to the AAMA Educational Fund.

(Please turn to page 835)

THE JOURNAL *Book Shelf*



BOOK REVIEWS

HEARING MECHANISMS IN VERTEBRATES, Ciba Foundation Symposium, ed. by *A. U. S. de Reuck* and *Julie Knight* (Boston, Little, Brown and Company, 1968).

This book is the fourth in a series of symposia on sensory function held at the Ciba Foundation. It was held September 26-28, 1967. Twenty-six members were responsible for the contributions to advance our knowledge of the structure and function of the hearing mechanisms.

Sections I and II establish the evolutionary hierarchy of the hearing mechanism in nonmammalian vertebrates and mammals. Section III deals with the afferent and efferent pathways in the auditory nerve. Section IV is devoted to orientation and auditory discrimination through sound localization.

This book is a compilation of both factual and speculative material. It serves to make the reader aware of recent developments as well as a guide to areas of potential research. It presents the formal papers and the informal discussions of the authors. Many fascinating bits of information are contained about the function and structure of the hearing mechanism especially in many of the mammalian families such as the porpoise. The book would seem to have its greatest value, however, in the library of the research scientists.—*Byron M. Merkel,* M.D.

DRUG ABUSE IN INDUSTRY, ed. by *W. Wayne Stewart,* M.D. (Miami, Halos & Associates, Inc., 1970. $8.75).

This book is a 268-page volume of papers read at a symposium given May 18-19, 1970 in Philadelphia. Sponsors of the symposium were Smith, Kline & French Laboratories, Sun Oil Company, Boeing Company—Vertol Division, Scott Paper Company, Campbell Soup Company and THE JOURNAL OF INDUSTRIAL MEDICINE AND SURGERY.

A casual perusal of this book is impossible. It is too interesting. You find yourself reading it word for word. It is an excellent book and should be read by each individual in a Personnel Department and each supervisor in each industry throughout the country. And it should be read now. Preparations for a coming problem then can be made.

Each physician in practice would benefit by reading this book. It tells how drug users can be detected, what to look for, what tests can be made, etc. Laboratories should plan equipment to handle tests in the future. These tests are not, at least at the present time, of the simple dip-stick type.

Drug abuse ties in with Workmen's Compensation. It prolongs healing time and thus adds to costs and disability. At the present time mental illness and secondly, alcoholism are the main culprits. The book predicts that drug abuse will be the major cause in the future.—C. *Harlan Johnston,* M.D.

HANDBOOK OF LEGAL MEDICINE, 3rd ed. by *Alan R. Moritz,* M.D., and *R. Crawford Morris,* LL.B. (St. Louis, C. V. Mosby Company, 1969).

This is truly an excellent reference giving concise and accurate answers to every conceivable medical-legal problem and the brevity is most appreciated. One can find an answer in seconds and be assured of its authenticity. The authors have had considerable experience in medical and legal publications. They have distilled their experience to a true handbook form, and I can recommend it as deserving a place of reference in the physician's or lawyer's office library.—*Mark D. Ravreby,* M.D., J.D.

SYNOPSIS OF EAR, NOSE AND THROAT DISEASES, 3rd ed., by *Robert E. Ryan,* M.D., *Joseph H. Ogura,* M.D., *Hugh F. Biller,* M.D., and *Lindsay L. Pratt,* M.D. (St. Louis, C. V. Mosby Company, 1970, $10.75).

This is the second revision of this book (1959), which has been widely accepted as a most excellent reference work in the field of otolaryngology. It was designed primarily for the use of the busy family physician, the intern, the medical student, nurses and voice and speech pathologists as a handy guide and ready reference.

The present edition retains the format of an inclusive, concise discussion of the common diseases of the ears, nose and throat, followed by an outline summary at the end of most of the chapters. The diseases are discussed in relation to their etiology, pathology, symptomatology, prognosis and therapy. The symptoms and treatment are repeated in outline form at the end of most of the chapters.

The original author (Ryan) with three new co-authors has, with 53 chapters and 365 pages, updated the work completely of the second edition which contained 58 chapters and 401 pages. It is understood that Hans von Leden, M.D., with Dr. Ryan, was an original author of parts of the volume.

This book is highly recommended as a ready reference to any student or physician who is interested in disorders of the ears, nose and throat. It makes no pretense of being encyclopedic and does not answer all the questions, but it is an excellent starting point. —*Byron M. Merkel,* M.D.

BOOKS RECEIVED

ESSENTIALS OF CLINICAL ENDOCRINOLOGY by *Norman G. Schneeberg,* M.D. St. Louis, C. V. Mosby Company 1970, $22.50).

CURRENT DERMATOLOGIC MANAGEMENT ed. by *Stuart Maddin,* M.D. (St. Louis, C. V. Mosby Company, 1970, $28.75).

THE FROZEN CELL, Ciba Foundation Symposium, ed. by G. *E. W. Wolstenholme* and *Maeve O'Connor.* (London, J. & A. Churchill Ltd., 1970).

CONTROL PROCESSES IN MULTICELLULAR ORGANISMS, Ciba Foundation Symposium, ed. by G. *E. W. Wolstenholme* and *Julie Knight.* (London, J. & A. Churchill Ltd., 1970).

BREATHING: HERING-BREUER CENTENARY SYMPOSIUM, Ciba Foundation Symposium, ed. by *Ruth Porter.* (London, J. & A. Churchill Ltd., 1970).

PROGESTERONE: ITS REGULATORY EFFECT ON THE MYOMETRIUM, Ciba Foundation Study Group No. 34, ed. by G. *E. W. Wolstenholme* and *Julie Knight.* (London, J. & A. Churchill Ltd., 1969).

SYNOPSIS OF ANATOMY by *Liberato J. A. DiDio,* M.D., Ph.D. (St. Louis, C. V. Mosby Company, 1970, $17.75).

STEREOSCOPIC MANUAL OF OCULAR FUNDUS IN LOCAL AND SYSTEMIC DISEASE, Vol. II, by *Frederic C. Blodi,* M.D., *Lee Allen,* and *Ogden Frazier.* (St. Louis, C. V. Mosby Company, 1970, $39.50).

UNIVERSITY HOSPITALS DRUG LETTER

(Continued from page 828)

therapeutic abortion and virus has not been found in any of the products of conception. In one instance, virus was detected in the placentae, but was not able to be recultured on a second pass in culture media. The incidence of congenital malformations from all causes is 2-3 per cent of live births. This undoubtedly would be a confusing issue if immunization was attempted in pregnant women.

If these approaches to eradication of rubella are to be successful, additional steps need to be taken by the medical community. First is the definite need to practice routine rubella immunization of all infants soon after their first birthdate to assure a continued high herd immunity. Secondly, there must be no barriers, either financial, geographic, or informational, to the accessibility of immunization to all children. A third necessity is for the medical community to practice careful surveillance techniques, and immediately report isolated or epidemic outbreaks of rubella, so that adequate epidemiologic studies can be accomplished for vaccine evaluation.

Specific contraindications to the use of vaccine include pregnancy, lymphoma, leukemia, or generalized malignancy. The vaccine should not be given to persons receiving steroids, alkylating drugs, antimetabolites or radiation therapy. Administration of rubella vaccine should be avoided for one month preceding or following the use of other live virus such as polio, rubeola, or mumps. Multiple live virus antigen vaccines are currently being developed.

Currently 300,000 Iowa children between one and 12 years have been immunized through a statewide campaign conducted by the Iowa State Department of Health with the cooperation of individual county medical societies. It is estimated that 90-92 per cent of all Iowa children will have been vaccinated by September, 1970. The incidence of arthralgia has been significant but in no instance permanent. No case of cardio-respiratory shock has occurred. The acceptance by the children has been excellent, in that all currently licensed materials produce much less of a "sting" than the vaccines used during the mass rubeola program several years ago.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

(Continued from page 833)

At the Inaugural Banquet, Ralph E. Snyder, M.D., Director, Professional Relations, Merck, Sharp & Dohme, announced a grant of $18,000 for AAMA programs, including Certification, Education, State and Local Chapter Meetings and the AAMA traveling certification exhibit.

Wyeth Laboratories previewed a new presentation entitled "A Filmed Tribute to the Medical Assistant."

Once again space does not permit listing all our sponsors and friends, those who support our AAMA but I must say "thank you" to the Iowa Medical Society and Iowa Medical Service for all their help and for the continental breakfasts on Friday and Saturday mornings.

The Parade of Presidents on Saturday evening, with 44 of our 47 organized States represented, including Hawaii and Alaska, was indeed a spectacular. Added to this was the guest appearance of Miss Elena Verdugo, better known to those who watch Marcus Welby, M.D., as Consuelo Lopez. Miss Verdugo was presented an honorary scroll commending her for her portrayal of the medical assistant.

To conclude these comments, and by far the most exciting part of the convention for me personally, was my election to the AAMA Board of Trustees. This is indeed an honor, and I am deeply grateful to the Iowa membership whose confidence in me I cherish. To my campaign manager, Mrs. Marcine Sanders, of Davenport, her committee, and especially to Mrs. Jean Gold who made all of the arm "garters" worn by our girls, and all Iowa members who worked in my behalf, my sincere thanks—it is my privilege to represent Iowa and AAMA.

Best wishes for a Happy Holiday Season.

JEANNE D. GREEN

Woman's Auxiliary News

MERRY CHRISTMAS! . . .

. . . and best wishes for the most meaningful holiday season of your life. May you have time for wonder and awe for the goodness around you and compassion when the ideal has not been possible.

Hopefully, you've had time to remobilize your forces after the fall push and the elections, and can look forward to redoubling your efforts in January for the final stretch of our Auxiliary year. You have received, or soon will, the call for the January Board meeting. Plan to be there! County presidents please note: join us to make plans for the spring and enjoy Medical Auxiliary fellowship.

The Fall Conference and Workshops in Chicago were inspiring and helpful. We missed those who were eligible and could not attend. It's an experience you can put in the credit column of Auxiliary activity. It may take a week to recover and get the house and family pulled together, but it's worth it. You will learn some of the reactions elsewhere in this issue. New material should have reached state and county committee chairmen.

It was a delightful afternoon! On Saturday, October 24, I attended the WASAMA luncheon and fall style show in Iowa City. I'm prejudice for there is a new WASMA member in our family; but you would be too, if you could see this group and experience the thrill of meeting these young women who are beginning Auxiliary work. They are attractive, sharp, intelligent, capable, dedicated and—precious. We have much to learn from them, and I hope we can support their efforts and match their enthusiasm. My visit to Scott County on November 20 was another highlight; this is another privilege in the credit column.

Supplies for Yucatan are beginning to come in. Thank you. I hope the sale of Christmas cards is bigger than ever and that all of your projects, large and small, bring you satisfaction and happiness.

As this year ends my thanks and appreciation for your loyal co-operation, your suggestions and most of all your service to the Woman's Auxiliary to the Iowa Medical Society.

MARION PREWITT

White House Conference on Children and Youth

On October 27, 1969, President Nixon officially called a White House Conference on Children and Youth for Washington, D. C., from December 13 to 18, 1970.

White House Conferences on Children and Youth have been held in every decade since 1909 when President Theodore Roosevelt summoned 200 citizens to a White House Conference dedicated to helping dependent children. In the ensuing years, the theme of each Conference has been changed to reflect the economic and social state of affairs at that time.

In 1960 some 7,500 delegates crowded into Washington to vote 670 recommendations on behalf of children and youth.

Mr. Stephen Hess, the 1970 Conference Chairman, is initiating a change in organization. He is splitting the White House Conference in two. The December 13-18 Conference will consider children up to age 14; a second Conference is scheduled in February on youth aged 14 to 24. Children and youth have two completely different sets of problems.

The topics chosen for the White House Conference on Children: Individuality; Learning; Health; Parents and Families; Communities and Environments; Laws, Rights, and Responsibilities; and Child Service Institutions.

The topics chosen for the White House Conference on Youth: Poverty; Race and Minority Group Relations; Values, Ethics, and Culture;

Legal Rights and Justice; Drugs; Economy and Employment; Education; Environment; Foreign Relations; and Draft, National Service, and Alternatives.

Commonwealth Conference

A Commonwealth Conference on Children and Youth was held November 19-20 in Iowa City to bring together ideas for use by those Iowans who will participate in the White House Conferences on Children and Youth in December and February.

The conference keynote speech was given by Catherine Richards, a special consultant to the Chief of Youth Services of the U. S. Department of Health, Education and Welfare.

Delegates to White House Conference

The Chairman of Iowa's Commission on Children and Youth has not received final notice as to the date of the February Youth Conference; the exact number of delegates remains unknown also, but the proportion will be one-third adults, two-thirds youth.

If you know of any young people (14-24) interested in attending, have them speak to faculty or advisors at their schools so they may be considered in the selection of Iowa's delegates. The students should write biographical sketches and submit them to Mr. C. J. Gauger, 32 Curtiss Hall, Iowa State University, Ames, Iowa 50010 (phone 515-294-1017), as soon as possible.

Although nothing was mentioned about selection of adult delegates, we imagine similar procedure would follow for adults who are interested.

An Eye-Opening Experience

As the new Health Careers Chairman of the Woman's Auxiliary, attending the North Central States Regional Workshop was an eye-opening experience. The meeting brought together Auxiliary Presidents, Presidents-Elect and Committee Chairmen from 12 states on October 15 and 16 at the Hotel Knickerbocker in Chicago.

Make no mistake about it, these workshops are not "shopping and gossiping trips." They are worthwhile work sessions; ideas and information from all the states involved were shared. I was very impressed with activities, enthusiasm and influence of the Auxiliaries from other states.

As a "State Auxiliary newcomer," I felt this workshop was very worthwhile, but one thought for new officers, a spring workshop would perhaps be more helpful in "learning the ropes and getting the year's plans underway."

JUNE MCKEEVER (MRS. EARL)
Health Careers Chairman

More Common Sense

On October 26-28 the National Coordinating Council on Drug Abuse Education and Information, Inc., held an important regional drug abuse workshop in Rosemont, Illinois.

The workshop theme was community action approaches to drug abuse. The emphasis was on "More Common Sense" and attention was given to community action at work, at home, at school and at play. The alternatives to outright panic were considered in dealing with drug users.

MARY ELLEN KIMBALL (MRS. J. D.)
State Chairman of Children and Youth, Woman's Auxiliary;
Member, Iowa Commission on Children and Youth.

NEWS . . . in the Culinary Arts

Members of the Wapello County Medical Auxiliary enjoyed preparing and serving the luncheon at the September state board meeting held at the home of Marion Prewitt. Many requests were made for the recipes, thus they are printed here for the benefit of all Auxiliary members.

MRS. NIXON'S HOT CHICKEN SALAD

4 cups cold cut-up cooked chicken
1 tablespoon lemon juice
¾ cup mayonnaise
1 teaspoon salt
½ teaspoon monosodium glutamate
2 cups chopped celery
4 hard cooked eggs, sliced
¾ cup cream of chicken soup
1 tablespoon onion finely minced
2 pimento cut fine
1 cup cheese grated
1 cup potato chips crushed
⅔ cup finely chopped toasted almonds

Combine all except potato chips, almonds, and cheese. Place in dish, top with cheese, potato chips and almonds. Let stand overnite in refrigerator. Bake at 400 degrees for 20-25 minutes. Serves 10.

CRANBERRY-RASPBERRY MOLD

2 3 ounce packages of raspberry jello
2 cups boiling water
1 pint sour cream
1 can cranberry sauce
1 package frozen raspberries

Mix jello and boiling water. Cool only until syrupy, then whip in sour cream. Continue beating until sour cream is dissolved in jello. Beat in cranberries until they too are all dissolved. Fold in frozen raspberries with juice. Pour into buttered mold and refrigerate until set. Serves 8-10.

For IOWANS, YUCATAN Is Just Down the Street

Only one movement, *The Partners of the Alliance,* which covers a major part of the hemisphere, has been able to bridge the mutual assistance gap between North America and Latin America. It has done so without resorting to governments. It was organized in 1964 as a new and different concept in mutual cooperation between the Americas; it makes governments helpful bystanders instead of principal parties.

In six years The Partners program has originated and carried out projects between the Americas valued at more than $15,000,000. Its programs have been of limitless value in human relations and understanding.

The concept provides for and promotes nonprofit, volunteer Partnerships between our 50 states and the nations, states or areas of Latin America. The program tries to find flexible, practical ways of developing social and economic self help projects. The program seeks to strengthen communication and understanding between the individual citizens of the two hemispheres.

The first effective Partnerships were formed in 1963 and 1964 when Utah, Texas, Idaho, Florida and Oregon linked up with their counterparts in Latin America. The number of participating states has grown to forty.

Compared to the turn of this century, today's world is village size, and no man can live in it comfortably or securely when his neighbor down the street is inadequately fed, housed and educated.

For IOWANS, YUCATAN is just down the street.

Actually, it is in Southeast Mexico, about 90 minutes by air from New Orleans. The culture of Iowa's sister state goes back to 1200 B.C. Yucatan is a peninsula with no rivers. The country's two or three inches of topsoil are essentially limestone sponge and they are 22 feet above sea level. Infant mortality is high because of the unsanitary condition of the water; 50 per cent of the babies die from malnutrition before they reach seven years of age; 50 per cent of those who do survive do not develop mentally because of the scarcity of food.

Supplementary foods are a dire need. The hospitals need up-to-date drugs, surgical instruments, Johnny Coats and hospital bedding. Won't you help?? For particulars, contact: Bunny Wicks (Mrs. R. L.), 523 South Clinton, Boone, or Mrs. R. L. Kent, 18 Oak Drive, Fort Madison.

In 1968 Lyndon Johnson said: "The Partnership is many things. It is the movement of hospital equipment and the sharing of medical knowledge; it is the exchange of art, music and literature in an enriching fellowship. It is volunteer specialists who give the time and talent to help build a better hemisphere. It is businessmen dealing with businessmen—and farmers working with farmers. It is all these and countless other personal relationships that combine to build bridges of understanding and bonds of shared ideals and responsibilities."

Around the Hawkeye State

Black Hawk County

The final meeting of the Auxiliary year was a May Breakfast in the home of Mrs. Thomas Thornton. The new officers were installed for the coming year. Mrs. Otto Della Maddalena succeeds Mrs. Orrin Hall as President.

The Black Hawk County Auxiliary has donated $500 to the Goodwill Industries for a steam table and food service equipment. This equipment will be used in the food preparation training program. The lunches prepared will be served to the trainees, many of whom come from the State Hospital in Independence. A second $500 was donated to the County Home for the purchase of adult playground equipment. Profits from the Auxiliary's annual Medicine Ball made these donations possible.

Buchanan County

The Buchanan County Auxiliary year began September 8. In October a Garage Sale was held with proceeds going to AMA-ERF. Drug, soap and bandage collections continued through the month.

On October 15 the Health Career Tea was given for all students from seventh through twelfth grades. Six persons from the medical field spoke and a question and answer period followed. Refreshments were served.

Robert T. Soper, M.D., professor of surgery, U. of I. College of Medicine, spoke on International

Health Activities at a joint meeting with the Medical Society in November.

A Thanksgiving-Christmas Dinner will be given for the Special Education School as in the past. And the annual Christmas Party at the County Home will be given in December.

A Silent Auction will be held during the December Auxiliary meeting, in addition to discussion for the Fourth Annual Dinner Dance to be held in April.

Cerro Gordo County

Committee chairmen were appointed when the Cerro Gordo Medical Auxiliary opened its year in October with a dinner meeting at the Sheraton Motor Inn.

Mrs. Walter Hansen, president, appointed Mrs. Rodger Smith to the American Medical Association Education Research Foundation; Mrs. Frank Kapke, Membership; Mrs. Harold Cahoy, Community Service; Mrs. Hallard Beard, Easter Seal Sale for Homebound Handicapped; Mrs. George West, Health Careers; Mrs. Stanley Vegors, Legislative; Mrs. George Tice, Program, and Mrs. Van Hunt, Publicity.

The local Homebound Handcraft Sale was held November 13, 14 and 15 at the Willowbrook Plaza in cooperation with the Easter Seal Society.

Marion County

The Marion County Medical Auxiliary met September 28 at the home of Mrs. R. C. Floren in Des Moines. Mrs. John Griffin conducted the business meeting after a lovely buffet luncheon was served by Mrs. Floren.

A report was given on the medical needs of Iowa's sister state, Yucatan, and it was decided to adopt this as an International Health project.

A favorable vote was cast to send a contribution to AMA-ERF.

Mrs. T. D. Clark reported on the fine progress which has been made in the Candy Stripe program at Collins Hospital in Knoxville.

An invitation was extended by Mrs. Earl McKeever to attend a political coffee in her home on October 26 for Mrs. Minnette Doderer.

Scott County

An unprecedented 50 women turned out for the opening meeting in September. Artificial and live flowers were used to develop Thanksgiving and Christmas arrangements in a program given by the floral firm of Flowers by Fredrick.

Dr. John Sunderbruch, Iowa Medical Society President, spoke at the October meeting and Dr. James Bishop, Auxiliary Advisor, and James Koch, Executive Secretary, Scott and Rock Island Medical Societies, were guests.

Mrs. Ronn Hoffman, Community Service Chairman, has announced preliminary plans for Auxiliary volunteer service at the Fairmont Cerebral Palsy Pre-school. Direct assistance will be provided to the children and a training session for those interested is being arranged.

Mrs. Ray Berger, the International Health Activities Chairman, has packaged and sent 505 pounds of drugs and 135 Johnny Coats. World Medical Relief receives these items and has informed Mrs. Berger that the antibiotics were among the first foreign supplies to reach the disaster area of Peru in June. Since they were of the type that did not require syringes or needles to administer, and because they were at the right place at a most necessary time thousands of lives were saved.

Wapello County

The Vice President of the Wapello County Auxiliary, Mrs. G. D. Emanuel, is active in the Ottumwa Voices for Prisoners of War. She has talked before women's groups and has organized a weekly letter-writing program; the letter-writers meet in the basement of the First Presbyterian Church every Thursday afternoon. To date approximately 500 letters have been sent to world leaders asking them to put pressure on Hanoi. They ask for a complete list of prisoners, adherence to the Geneva Convention and agreement to the release of all prisoners. Anyone wanting more information on this project may write to Mary at 5 Raynan Drive, Ottumwa 52501.

Medical families hosted the refreshing and talented young persons who make up the "Up with People" musical organization when the group visited Ottumwa recently.

It is with regret that the Auxiliary reports the death of Mrs. E. B. Howell, September 9, 1970, at a nursing home in South Bend, Indiana.

WOMAN'S AUXILIARY TO THE IOWA MEDICAL SOCIETY

President—Mrs. L. H. Prewitt, 33 Birchwood Hills, Ottumwa 52501

President-Elect—Mrs. P. H. Tenney, 203 Second Avenue, SW, Independence 50644

Recording Secretary—Mrs. O. A. Elliott, 4010 Welker Avenue, Des Moines 50312

Treasurer—Mrs. J. F. Veverka, Box 324, Prairie City 50228

Editor of THE NEWS—Mrs. J. L. Kehoe, 111 McClellan Blvd., Davenport 52803



Personals



Dr. R. M. Caplan, professor of dermatology and assistant dean for continuing education and **Dr. I. V. Ponseti,** professor of orthopedic surgery at The U. of I. College of Medicine, participated in the annual Podiatric Institute held at the Iowa Memorial Union in Iowa City. Dr. Caplan's topic was "A Dermatologist Looks at the Foot," and Dr. Ponseti spoke on "Tendon Transfers in the Treatment of the Club Foot." The institute was sponsored by the University of Iowa Center for Conferences and Institutes, in cooperation with the Iowa Podiatry Association.

Dr. William P. Wellington, of Des Moines, has been appointed to serve as a temporary deputy Polk County medical examiner until the end of 1970. Four deputy positions have been created by the Polk County Board of Supervisors to allow medical doctors and osteopaths recommended by their county professional organizations to gain experience in medical examiner work and ultimately to succeed **Leo Luka, D.O.,** who has indicated he plans to retire. The other three deputies have not been appointed.

Dr. C. W. Maplethorpe, Jr., of Toledo, participated in a panel discussion at a recent meeting of the Iowa Council of Homemaker-Health Aide Agencies in Ames. The topic for discussion was how the health service helps fill the needs of rural people and how home health care should be an integral part of all comprehensive health planning of Iowa.

Dr. O. E. Senft, of Monticello, spoke on drug abuse at a recent meeting of the Business and Professional Women's Club in Monticello.

Dr. H. W. Van Hofwegen, of Newton, was guest speaker at a recent meeting of the Central Division of the Iowa Heart Association in Newton.

Dr. Matthew P. Lawler, a Des Moines obstetrician and gynecologist, presided at the eleventh annual Mercy Hospital Medical Day in Des Moines. **Dr. Michael Yannone,** professor of obstetrics and gynecology at The U. of I. College of Medicine, was among the lecturers at the day-long educational seminar.

Dr. Ernest N. Lerner, formerly on the staff of the Mt. Pleasant Mental Health Institute, has leased the office of the late **Dr. William Megorden** and is engaged in the practice of general medicine. Dr. Lerner was graduated from Louisiana State University School of Medicine in 1946. He served his internship at Kings County Hospital in New York. Following military service, Dr. Lerner completed one year of residency training in chest diseases and three years in internal medicine.

A program marking the 50th anniversary of the opening of the State Psychopathic Hospital was held at The U. of I. in October. **Dr. Paul E. Huston,** professor and head of psychiatry and director of the hospital since 1956, **Dr. Robert C. Hardin,** vice-provost and dean for health affairs, **Dr. Garfield Tourney,** professor of psychiatry, and **Dr. Leonard L. Heston,** associate professor of psychiatry at The U. of I. College of Medicine, were among those participating in the program.

Dr. Robert D. Whinery, an Iowa City ophthalmologist, has been named a fellow of the American College of Surgeons. Dr. Whinery is a graduate of The U. of I. College of Medicine and has completed postgraduate work in ophthalmology. He is a member of the Mercy Hospital medical staff in Iowa City.

Dr. Kenneth Johannsen, of Spencer, was the guest speaker at a workshop for nursing and paramedical personnel held in Spencer recently. Dr. Johannsen's topic was "Stroke—The Overview."

Drs. John C. MacQueen and **Sidney S. Kripke**, faculty members of the Department of Pediatrics at The U. of I. College of Medicine, participated in an ear, nose and throat clinic conducted in West Union and sponsored by the State Services for Crippled Children.

Dr. Hrair P. Gulesserian, assistant professor of surgery at The U. of I. College of Medicine, has been named a fellow of the American College of Surgeons. Dr. Gulesserian received the M.D. degree from the American University in Beirut, Lebanon. He came to The U. of I. in 1967 and was appointed assistant professor of surgery in 1969.

Dr. and Mrs. Emmet Ayers, of Charles City, and **Dr. and Mrs. C. W. Clark** of Nashua, recently returned from a three-week trip abroad. Dr. Ayers and Dr. Clark attended medical seminars in Copenhagen, Denmark; Wiesbaden, Germany; Paris, France; and London, England.

Dr. H. E. Rudersdorf, of Sioux City, presided recently at the fall meeting of the Northwest Division of the Iowa Heart Association in Cherokee. **Dr. John T. Bakody**, a Des Moines neurosurgeon, was the guest speaker. Dr. Bakody explained the hospital-based stroke unit. **Dr. F. B. O'Leary**, of Sibley, state director of the Iowa Heart Association, attended the meeting.

Drs. Norman Lowe and **William D. Johnson**, both pathologists, have been appointed to the medical staff of Sacred Heart Hospital in Fort Madison. Both are diplomates of the American Board of Pathology. Dr. Lowe received his medical degree from Johns Hopkins University at Baltimore in 1953. He served his internship at the New York Hospital—Cornell University Medical Center. Dr. Johnson received his medical degree from the Long Island College of Medicine at Brooklyn in 1949. He served his internship in San Francisco.

Dr. John Doran, an Ames obstetrician and gynecologist, appeared during October on the WOI-TV program called "Dimension 5." Dr. Doran discussed therapeutic abortion.

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Dr. Douglas Johnson has been named psychiatrist and director of the Clinton Mental Health Center. He was appointed to a one-year term. Dr. Johnson has been associated in private practice in Dubuque with **Dr. Richard Lee** and has been a member of the Mercy Hospital staff there. He received his M.D. degree at Baylor University in Houston, Texas, interned at Jefferson Davis and Texas Children's Hospital in Houston and spent three years as a resident physician at The U. of I. Psychopathic Hospital. A former clinical director of the Iowa Security Medical Facility at Anamosa and Oakdale, Dr. Johnson entered private practice in Dubuque last March.

Dr. Dale A. Harding, of Eagle Grove, is one of nine individuals from across the country whose views were contained in a series of articles on medical office design and improvement which appeared in the September 30, 1970, issue of PATIENT CARE magazine.

Dr. Walter M. Block, of Cedar Rapids, presented a paper on "Cerebral Dysfunction" at a recent regional conference of the American Association of Mental Deficiency held in Winnipeg, Canada.

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In honor of **Dr. Harold W. Morgan,** of Mason City, the structure which houses the Iowa Division, Inc., American Cancer Society, will become known as the Morgan Building. Dr. Morgan is widely recognized as the volunteer who spearheaded the creation of a cancer control group in Iowa. During a special "Open House" ceremony, an oil painting of Dr. Morgan was presented to the Iowa Division.

Dr. J. E. O'Donnell, of Clinton, has been appointed to the Clinton Air Pollution Control Commission. Dr. O'Donnell is the city health physician.

Dr. Adrian E. Flatt, professor of orthopedic surgery at The U. of I. College of Medicine, has received a five-year grant of $285,737 to direct a research team in the study of the wrist. The grant was made by the arthritis and metabolic diseases section of the National Institutes of Health. The study will seek improved treatment methods for serious wrist disorders caused by birth defect, accident or disease.

Dr. Lewis Harned, Waterloo orthopedic surgeon, spoke at a recent meeting of the Irving Pre-School group in Waterloo. His topic was "Common Feet and Leg Problems in Pre-School Children."

Among the Iowa physicians attending the annual Scientific Assembly of the American Academy of General Practice in San Francisco were **Drs. D. C. Carver,** of Rockwell City, **Larry H. Boeke,** of West Union, **Ralph Gorrell,** and **Charles Hawkins,** both of Clarion, **Rodmond Smith,** of Red Oak, and **Edward Croxdale,** of Villisca.

Dr. William B. Bean, Sir William Osler professor of internal medicine at The U. of I. College of Medicine, was a recent visiting professor at Emory University in Atlanta, Georgia. He spoke on "Walter Reed and the American Frontier," and "William Osler as a Practical Joker," and conducted Grand Rounds. On November 5, Dr. Bean was the guest speaker at the annual meeting of the Southern Illinois Medical Society in Belleville, Illinois. His topic was "New Light on Walter Reed."

Dr. Dale Liechty, professor of surgery at The U. of I. College of Medicine, was the guest speaker at a meeting of the Wright County Medical Society in Belmond. Dr. Liechty spoke on "Newer Concepts of Breast Disease."

Dr. Robert E. Condon, currently a professor of surgery at the University of Illinois College of Medicine, has been named professor and head of the Department of Surgery at The U. of I. College of Medicine. **Dr. Sidney E. Ziffren,** who has served as acting head of the department since July, 1969, will continue in that position until Dr. Condon's arrival. Dr. Condon received the M.D. degree at the University of Rochester in 1957. He interned at King County Hospital in Seattle, Washington and took his residency training in surgery at the University of Washington. He was named senior fellow in surgery there in 1960 and instructor in surgery in 1962. From 1961 to 1963, he was postdoctoral fellow of the National Heart Institute. In 1963, he received a Guggenheim Fellowship for the study of human liver diseases at the Royal Free Hospital, London. He was appointed assistant professor of surgery at Baylor in 1965. While at Baylor, he received the senior class award as the outstanding full-time faculty member and the Annual Phi Chi Award for excellence in teaching. Dr. Condon joined the Illinois faculty as an associate professor in 1967 and was appointed professor of surgery in 1969.

Dr. Linda Fahr has joined the staff of the Gilfillan Clinic in Bloomfield. A 1968 graduate of The U. of I. College of Medicine, Dr. Fahr served her internship at St. Joseph Hospital in Milwaukee, Wisconsin, and her residency in psychiatry at Marquette Hospital in Milwaukee. She has been working in emergency service at St. Joseph Hospital in Milwaukee. Dr. Fahr is the daughter of **Dr. and Mrs. P. T. Meyers** of Bloomfield.

Dr. Noel Kerr, a general practitioner and anesthesiologist, began the practice of medicine in Dyersville in early October. Dr. Kerr, a native of Dublin, Ireland, formerly practiced in Reno, Nevada.

Dr. Dean Nierling, of Cresco, has been selected for inclusion in the 1970 edition of OUTSTANDING YOUNG MEN OF AMERICA. Dr. Nierling was cited for his many and varied community activities and his work with youth in the area.



Dr. James Bullard, of Decorah, participated in a recent four-session adult education seminar on "Parent to Child Relationship," at the Turkey Valley High School in Jackson Junction. Dr. Bullard's topic was drug abuse in rural Iowa.

Dr. Chester McClure, psychiatrist and director of the alcohol and drug unit at the Mental Health Institute in Independence, discussed the drug problem recently at the North Winneshiek Community School in Burr Oak.

Drs. Thomas Spragg, O. W. Hall, Andrew Smith, and **Heinz S. Jacobi**, all of Waterloo, participated in an intensive day-long training program in cardiopulmonary resuscitation (CPR) sponsored by the Northeast Division of the Iowa Heart Association. Forty-one nurses and physicians from 14 area hospitals attended. Purpose of the program was to train teams of professional people in the area so they can in turn set up and direct CPR programs in their own hospitals and communities.

Dr. Carleton T. Helseth, of Sioux City, attended the 47th annual General Council of the American Interprofessional Institute at St. Joseph, Missouri.

Dr. Richard Utne, a Mason City radiologist, was the featured speaker at an Inter Se Study Club sponsored meeting in Northwood. Dr. Utne told of his experiences aboard the ship, S.S. Hope.

Dr. Montague S. Lawrence, professor of surgery at The U. of I. College of Medicine, and **Dr. W. C. Baumann**, of Fairfield, participated in a ceremony proclaiming October 25-31 "Cleaner Air Week." The ceremony took place in the Governor's Office at the State Capitol Building. Dr. Lawrence is president of the Iowa Thoracic Society and Dr. Baumann is vice-president of the Iowa Tuberculosis and Respiratory Diseases Association, which sponsored the proclamation.

Dr. Robert E. Durnin, a pediatric cardiologist at The U. of I. College of Medicine, presented a recent seminar in cardiac auscultation at Westmar College in LeMars. Physicians from Plymouth County and the neighboring counties of Sioux, Woodbury, and Cherokee were in attendance.

Dr. Richard McKay, of Waterloo, spoke on eye problems in children at a fall meeting of the Black Hawk County Medical Assistants.

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Dr. Y. B. Mok, of Toronto, Canada, has joined the Park Clinic in Mason City. Dr. Mok will limit his practice to orthopedic and traumatic surgery. Before moving to Mason City, he served a residency in pathology at St. Joseph's Hospital in Toronto. Prior to that, he served residencies in orthopedic surgery in Hamilton and Ottawa, Canada, and a residency in general surgery at New Brunswick, Canada. Dr. Mok received his M.D. degree at the National Defense Medical Center, Taiwan, in 1962. He interned at Youngstown Hospital, Youngstown, Ohio, and then was a resident in general surgery at St. Mary of Nazareth Hospital, Chicago. From 1964 to 1965 he was house physician at Walther Memorial Hospital, Chicago. His wife is also a physician, specializing in anesthesiology.

Four faculty members of The U. of I. College of Medicine, Department of Obstetrics and Gynecology, participated in the recent District VI meeting of the American College of Obstetricians and Gynecologists in St. Paul, Minnesota. A paper on "Cancer Immunology in Detection, Treatment and Prevention of Gynecologic Malignancy," was given by **Dr. Herbert Buchsbaum,** assistant professor, and **Dr. Roy T. Pitkin,** associate professor, spoke on "Placental Transmission and Fetal Distribution of Saccharin." **Dr. Robert M. Kretzschmar,** associate professor, and **Dr. Michael E. Yannone,** professor, participated, respectively, in panels on "Merits and Demerits of the Pill" and "Anovulation."

Dr. John Lanning, of Charles City, has opened an office in Clarksville on a part-time basis. Dr. Lanning will see patients in that community four afternoons each week. A native of Tulsa, Oklahoma, Dr. Lanning was graduated from the University of Oklahoma School of Medicine in 1960. He interned at Kern County Hospital in Bakersfield, California, and then spent three years in the Navy Medical Corps, serving in Japan. After his discharge from the Navy, he accepted a residency in internal medicine at the University of Minnesota and for the past three years has been in practice in Charles City. He will continue to maintain his Charles City office.

Dr. John E. Rawls, an Ottumwa physician who has been associated with the South Ottumwa Medical Center, has announced he will begin a solo practice of medicine. Dr. Rawls is building an office in south Ottumwa which he expects to occupy in the spring. He is temporarily located in the Hofmann Building.

Dr. James Carr, of New Hampton, recently attended a meeting on "Emergency Medical Care," in Las Vegas, Nevada.

Dr. Ismael M. Naanep has joined the obstetrical and gynecological practice of **Drs. Milton S. Mark** and **Michael R. Hirsch** in Des Moines. Dr. Naanep received the M.D. degree at the University of Santo Tomas, Manila, Philippines. He interned at Mercy Hospital in Des Moines and completed his residency training in obstetrics and gynecology at the Northwestern University Medical Center in Chicago.

Deaths

Dr. R. W. Peterson, 72, died October 11 at a Mason City hospital. Dr. Peterson practiced at Kanawha from 1929 until 1937. He then moved to Clear Lake where he practiced until his retirement in 1962. He attended The U. of I. College of Medicine and completed his graduate work at Northwestern University in 1927. Dr. Peterson was city health officer for Clear Lake and Ventura for many years and was a member of the Iowa Medical Society, American Medical Association, Lions Club and American Legion.

Dr. John H. Tait, 77, retired eye, ear, nose and throat specialist, died October 29 at Iowa Lutheran Hospital in Des Moines. A graduate of the University of Kansas Medical School, Dr. Tait also attended the University of Vienna Medical School. He was a past president of the Polk County Medical Society, a member of the Za Ga Zig Shrine, the Iowa Medical Society and the American Medical Association.

Dr. Douglas H. Brown, 67, died October 15 at his home in Forest City. A 1928 graduate of The U. of I. College of Medicine, Dr. Brown was a member of the staff of Mercy and St. Luke's Hospitals in Davenport, as well as a member of the teaching staff in the Mercy School of Nursing. He was chief of staff at Forest City Hospital at the time of his death. Dr. Brown served two terms as president of the Winnebago-Hancock County Medical Society, and was a member of the Iowa Medical Society and American Medical Association.

Dr. Herbert H. Harris, 62, died October 25 at his home in Sioux City. A graduate of the Loyola Medical Center in Chicago, Dr. Harris established his practice in Morningside in 1948 after serving with the Army Medical Corps during World War II. He was on the staff of both St. Vincent Hospital and St. Luke's Medical Center in Sioux City. He was a member of the White Horse Mounted Patrol, Sioux City Consistory, Abu Bekr Shrine Temple, and Iowa Medical Society.


Gone with the wind

LIST YOUR WANTS

No charge is made for the ads of members, wives of deceased members of the Iowa Medical Society or physicians seeking Iowa locations; for others the cost is $1.00 per line, $5.00 minimum per insertion. Copy for ad must be received by the seventh of the month for the following issue. Send to JOURNAL OF THE IOWA MEDICAL SOCIETY, 1001 Grand, West Des Moines 50265.

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THE JOURNAL

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Index to Volume LX • Numbers 1-12 • 1970

Abortions, Therapeutic, at University Hospitals, 1951-1969, with emphasis on current trends, David W. Wetrich, M.D., and Lowell R. Hughes, M.D. 691
Acosta-Rua, Gaston J., M.D., Treatment of traumatic paraplegic patients by localized cooling of spinal cord. 326
Admission requirements, College of Medicine 240
Alberts, Marion E., M.D., and Bong Sik Han, M.D., Congenital nephrotic syndrome: case with electron microscopic and family studies 760
Alberts, Marion E., M.D., Tetanus and polio immunizations (editorial) 336
Alcoholics, Let's not be sentimental about (editorial).... 34
Alexander, James K., M.D., Recognition of pulmonary embolism 114
American Association of Medical Assistants, State of Iowa, Inc. 724, 779, 833
AMA and JAYCEES launch project 381
AMA film on sex education 31
AMA issues its eighth booklet on athletic training tips... 37
AMA Judicial Council frowns on physicians treating close relatives 118
AMA offers to lend new film on role of medical witness . 47
AMA to public, New pamphlet explains 274
Anderson, Rodney A., M.D., Oculoglandular tularemia: case report 21
Angiocardiography, Manuel Viamonte, Jr., M.D., Frank J. Hildner, M.D., and Carl E. Fabian, M.D. 644
An ideal parent-child relationship (editorial) 33
Anti-anxiety agents, Richard Finn, M.D. 583
Anticoagulant therapy, Views on (editorial) 580
Appoint Dr. Eckstein U. of I. medical dean 309
Arterial hypertension: diagnosis and treatment (editorial) 110
At Christmas and beyond (editorial) 829
Audiovisual techniques in teaching of anatomy: television, W. K. Metcalf, M.D., D. J. Moffatt, M.B., Ch.B., D. A. Griffiths, M.B., Ch.B., and A. W. Jacobs, M.A.. 26
Ave atque vale! (editorial) 34
Azothioprine in treatment of thrombocytopenic purpura (editorial) 264

Bean, William B., M.D., University of Iowa College of Medicine: 100 years ago 237
Bekhrad, A., M.D., and D. A. Culp, M.D., Giant calculus in diverticulum of male anterior urethra 699
Block, Walter M., M.D., Capsule review of mental retardation 393
Bonney, W. W., M.D., Kidney transplantation in Iowa: progress report 247

Camp Hertko Hollow 207
Capsule review of mental retardation, Walter M. Block, M.D. 393
Cardiac resuscitation, Community hospital experience with emergency, L. W. Swanson, M.D. 569
Cardelli, Robert M., M.D., and William F. McCormick, M.D., Rupture of left subclavian artery and fatal hemorrhage in patient with multiple neurofibromatosis .. 24
Careful food handling a must (editorial) 771
Cardiac pacing (editorial) 709
Case report: occupational exposure to insecticide naled, David L. Mick, Ph.D., Thomas D. Gartin, M.D., and Keith I. Long, Ph.D. 395
Century of distinguished service (editorial) 263
Cervical lymph node biopsies (editorial) 776
College of medicine admission requirements 240
College of Medicine in the 70's, John W. Eckstein, M.D. 802
College of medicine recognizes preceptors 241
Coming meetings 37, 82, 194, 234, 308, 381, 552, 616
Community hospital experience with emergency cardiac resuscitation, L. W. Swanson, M.D. 569
Congenital nephrotic syndrome: case with electron microscopic and family studies, Bong Sik Han, M.D., and Marion E. Alberts, M.D. 760
Congressman's response to alleged medicaid and medicare abuses, In the Public Interest facing p. 38
Continuous suction therapy of pneumothorax in newborn infant: rapid, cribside technique, James W. Hopkins, M.D., and Charlotte Fisk, M.D. 631
Control of bleeding in hemophilic patients (editorial) . 34
Council evaluates foundation concept 656
County Society Officers 532
Cox, Joseph A., M.D., and Robert T. Soper, M.D., Malrotation of midgut 317
Crohn's disease and its similarity to sarcoidosis, Possible agent in the transmission of, D. A. Glomset, M.D. (editorial) 773
Crowley, Daniel F., M.D., Spaceship earth (editorial) . 334
Culp, D. A., M.D., and A. Bekhrad, M.D., Giant calculus in diverticulum of male anterior urethra 699

Danger of extremism (editorial) 405
Davidson, Paul T., M.D., Massive hemothorax caused by bleeding from intercostal artery 389
Deaths 66, 138, 216, 290, 365, 429, 601, 662, 729, 789, 845
De Garvin, Elmer L., M.D., Richard D. Liechty, M.D., and Frederic W. Stamler, M.D., Metastasizing thyroid cancer ten years after radioactive iodine treatment for hyperthyroidism 16
Decker, D. A., Jr., M.D., and R. W. Fincham, M.D., L-Dopa therapy in Parkinson's disease (year's experience with 20 patients) 755
Degerming solutions for surgical scrub and skin preparation, John A. Gius, M.D. 339
Delayed spontaneous rupture of splenic hemangioma, Wm. W. Jones, M.D., and Wm. A. Sybers, M.D. ... 706
Diagnosing venous thrombosis (editorial) 712
Diagnosis and management of prepartum female with acute symptoms of hypertension and uremia, Kennedy C. Fawcett, M.D., John Sibley, M.D., and David Wall, M.D. 570
Digitalis therapy (editorial) 710
Discipline: central issue of our times (editorial)..... 267
Diverticulosis and diverticulitis of colon (editorial) ... 107
Doctor's Business 50, 121, 196, 280, 349, 418, 587, 648, 688, 777, 808
Doctors' fees just ten per cent of medicaid costs in Minnesota 44
Dreifus, Leonard S., M.D., Use of anti-arrhythmic agents other than digitalis 192
Drug data via telephone 818
Drug use and abuse, Psychiatric and legal aspects of ... 31
Durnin, Robert E., M.D., Dorothy A. Ehmke, M.D., and John B. Flege, M.D., Tetralogy of Fallot 171
Dustan, Harriet P., M.D., Etiology and pathogenesis of hypertension 344
Dustan, Harriet P., M.D., Treatment of hypertension ... 585

Early discharge of surgical patients (editorial) 829
Eckstein U. of I. medical dean, Appoint Dr. 309
Eckstein, John W., M.D., College of Medicine in the 70's 802
Educational opportunity program in college of medicine. 271
Ehmke, Dorothy A., M.D., Robert E. Durnin, M.D., and John B. Flege, M.D., Tetralogy of Fallot 171
Ehrenhaft, J. L., M.D., N. P. Rossi, M.D., and P. R. Recinos, M.D., Tuberculosis and bronchogenic carcinona 255
Etiology and pathogenesis of hypertension, Harriet P. Dustan, M.D. 344
Evaluation and treatment of respiratory allergy in Iowa, Hal B. Richerson, M.D., Paul M. Seebohm, M.D., and J. Montgomery Smith, M.D. 559
Extracranial arterial disease (editorial) 641

Fawcett, Kennedy C., M.D., John Sibley, M.D., and David Wall, M.D., Diagnosis and management of prepartum female with acute symptoms of hypertension and uremia 570
Ferguson, Roger K., M.D., Pentazocine 112
Fifty Year Club Members 531
Fincham, R. W., M.D., and D. A. Decker, Jr., M.D., L-Dopa therapy in Parkinson's disease (a year's experience with 20 patients) 755

Fine, Edna, M.S.W., Takeshi Shoji, M.A., Richard L. Jenkins, M.D., and Robert Gants, M.A., Interrupting family cycle of violence 85
Finn, Richard, M.D., An Iowa family with Huntington's chorea 89
Finn, Richard, M.D., Anti-anxiety agents 583
Fisk, Charlotte, M.D., and James W. Hopkins, M.D., Continuous suction therapy of pneumothorax in newborn infant: rapid, cribside technique 631
Flege, John B., M.D., Robert E. Durnin, M.D., and Dorothy A. Ehmke, M.D., Tetralogy of Fallot 171
Foundation concept, Council evaluates 656

Gants, Robert, M.A., Takeshi Shoji, M.A., Edna Fine, M.S.W., and Richard L. Jenkins, M.D., Interrupting family cycle of violence 85
Gartin, Thomas D., M.D., David L. Mick, Ph.D., and Keith R. Long, Ph.D., Case report: occupational exposure to insecticide naled 395
Giant calculus in a diverticulum of the male anterior urethra, A. Bekhrad, M.D., and D. A. Culp, M.D. ... 699
Gius, John A., M.D., Degerming solutions for surgical scrub and skin preparation 339
Glomset, D. A., M.D., Possible agent in the transmission of Crohn's disease and its similarity to sarcoidosis (editorial) 773
Golf Crown, Retains IMS 416
Gordon, David F., M.D., Tuberculous peritonitis: use of hook needle biopsy 819
Grant, Kingsley B., M.D., and Richard L. Sedlacek, M.D., Uterus didelphys with adenocarcinoma in one fundus—case report 324
Greetings from office of dean 236
Griffiths, D. A., M.B., Ch.B., W. K. Metcalf, M.D., D. J. Moffatt, M.B., Ch.B., and A. W. Jacobs, M.A., Audiovisual techniques in teaching of anatomy: television... 26

Hamilton, H. E., M.D., D. L. Landstrom, M.D., and R. F. Sheets, M.D., Peripheral blood response to thyrotoxicosis 183
Han, Bong Sik, M.D., and Marion E. Alberts, M.D., Congenital nephrotic syndrome: case with electron microscopic and family studies 760
Hass, A. Curtis, M.D., Donna L. Sooby, Ph.D., Herbert L. Jackson, Ph.D., Reproductive factors associated with radiotherapy of malignant lymphomas 636
Health care legislation considered by 1970 general assembly, In the Public Interest facing p. 398
Healy, Alfred, M.D., Rubella vaccines 828
Healy, Madelene Donnelly, M.D., Seven-year review of maternal and perinatal deaths 329
Hemophilic patients, Control of bleeding in (editorial) . 34
High risk obstetric patient (editorial) 829
Highway carnage (editorial) 577
Homosexuality, Medical approach to male, Richard A. Truax, M.D., William S. Moeller, M.D., and Garfield Tourney, M.D. 397
Hoosier success (editorial) 775
Hopkins, James W., M.D., and Charlotte Fisk, M.D., Continuous suction therapy of pneumothorax in newborn infant: rapid, cribside technique 631
Hospital administration and medical staff: working together for innovation, Gerald W. Mungerson 311
Hughes, Lowell R., M.D., and David W. Wetrich, M.D., Therapeutic abortions at University Hospitals, 1951-1969, with emphasis on current trends 691
Huntington's chorea, An Iowa family with, Richard Finn, M.D. 89
Husband's responsibility (editorial) 581
Hypertension and uremia, Diagnosis and management of prepartum female with acute symptoms of, Kennedy C. Fawcett, M.D., John Sibley, M.D., and David Wall, M.D. 570
Hypertension, Treatment of, Harriet P. Dustan, M.D. ... 585

Idiopathic thrombocytopenic purpura in childhood: approach to therapy, James C. Taylor, M.D. 94
Immunization levels need constant attention (editorial) .. 774
Importance of advising patient (editorial) 334
Impressed by American youth (editorial) 712
Inaugural remarks—J. H. Sunderbruch, M.D. 446
Index to minutes of 1970 IMS House of Delegates 536
Index to Volume LX, 1970 851
Indications for the use of anticoagulants in stroke syndromes, John R. Taylor, M.D., and Maurice W. Van Allen, M.D. 767
Informational report—Scanlon Medical Foundation/Iowa Medical Society 491
Ingestion of caustic substances (editorial) 189
INHA appoints new director 620
In the Public Interest (Congressman's response to alleged medicaid and medicare abuses) facing p. 38, (Iowa Medical Society is a representative democracy) facing p. 142, (Organizational structure of Iowa Medical Society) facing p. 222, (Iowa Medical Society policymaking: a thoughtful process) facing p. 262, facing p. 338, (Health care legislation considered by 1970 general assembly) facing p. 398, (Medical practice in Iowa—Why? Why Not?) facing p. 494, (Rubella program—study in fulfillment) facing p. 582, (Under study—foundation for medical care) facing p. 670, (Iowa, a place to grow) facing p. 690, (Is the mischief in drugs or in people?) facing p. 754, (Iowa legislators go to work next month) facing p. 854
Insecticide naled, Case report: occupational exposure to, David L. Mick, Ph.D., Thomas D. Gartin, M.D., and Keith R. Long, Ph.D. 395
Interrupting family cycle of violence, Richard L. Jenkins, M.D., Robert Gants, M.A., Takeshi Shoji, M.A., and Edna Fine, M.S.W. 85
In wisdom of congress 233
Iowa, a place to grow, In the Public Interest . facing p. 690
Iowa Association of Medical Assistants 46, 120, 198, 273, 343, 413, 588, 651
Iowa family with Huntington's chorea, Richard Finn, M.D. 89
Iowa Heart Association, Information from, (Prosthetic replacement of mitral valve) 42; (Recognition of pulmonary embolism) 114; (Use of anti-arrhythmic agents other than digitalis) 192; (Newer concepts of evaluation of cardiac function) 269; (Etiology and pathogenesis of hypertension) 344; (Tetralogy of Fallot) 411; (Treatment of hypertension) 585; (Angio-cardiography) 644.
Iowa legislators go to work next month, In the Public Interest facing p. 854
Iowa Medical Miscellany 684, 748, 809
Iowa physicians analyze rear-end collisions (editorial) .. 263
IRMP initiates medical literature network 331
Is the mischief in drugs or in people?, In the Public Interest facing p. 754

Jackson, Herbert L., Ph.D., A. Curtis Hass, M.D., and Donna L. Sooby, Ph.D., Reproductive factors associated with radiotherapy of malignant lymphomas..... 636
Jacobs, A. W., M.A., D. A. Griffiths, M.B., Ch.B., W. K. Metcalf, M.D., and D. J. Moffatt, M.B., Ch.B., Audiovisual techniques in teaching of anatomy: television... 26
Jenkins, Richard L., M.D., Robert Gants, M.A., Takeshi Shoji, M.A., and Edna Fine, M.S.W., Interrupting family cycle of violence 85
Jones, Wm. W., M.D., and Wm. A. Sybers, M.D., Delayed spontaneous rupture of a splenic hemangioma 706
Journal Book Shelf 39, 350, 715, 834

Kidney transplantation in Iowa: progress report, William W. Bonney, M.D. 247
Korns, Michael E., M.D., and Gerald J. Shirk, B.S., Possible traumatic rupture of aortic valve, bacterial endocarditis and bilateral coronary embolism 180
Krigsten, W. M., M.D., President's address—Medicine's survival in seventies 443

Landstrom, D. L., M.D., H. E. Hamilton, M.D., and R. F. Sheets, M.D., Peripheral blood response to thyrotoxicosis 183
L-Dopa therapy in Parkinson's disease (a year's experience with 20 patients), R. W. Fincham, M.D., and D. A. Decker, Jr., M.D. 755
Let's not be sentimental about alcoholics (editorial) 34
Liechty, Richard D., M.D., Elmer L. De Garvin, M.D., and Frederic W. Stamler, M.D., Metastasizing thyroid cancer ten years after radioactive iodine treatment for hyperthyroidism 16
Life and Associate Memberships 515
Long and distinguished service (editorial) 187
Long, Keith R., Ph.D., David L. Mick, Ph.D., and Thomas D. Gartin, M.D., Case report: occupational exposure to insecticide naled 395

McCormick, William F., M.D., and Robert M. Cardelli, M.D., Rupture of left subclavian artery and fatal hemorrhage in patient with multiple neurofibromatosis.... 24
Malm, James R., M.D., Tetralogy of Fallot 411
Malrotation of midgut, Joseph A. Cox, M.D., and Robert T. Soper, M.D. 317
Marihuana and reason, Physician, A. S. Norris, M.D. ... 623
Massive hemothorax caused by bleeding from an intercostal artery, Paul T. Davidson, M.D. 389
Maternal and perinatal deaths, Seven-year review of, Madelene Donnelly Healy, M.D. 329
Medical approach to male homosexuality, Richard A. Truax, M.D., William S. Moeller, M.D., and Garfield Tourney, M.D. 397
Medical Meetings 681, 745, 855
Medical practice in Iowa—Why? Why Not?, In the Public Interest facing p. 494
Medicare-Medicaid pay 69% 645
Mental retardation, Capsule review of, Walter M. Block, M.D. 393
Metastasizing thyroid cancer ten years after radioactive iodine treatment for hyperthyroidism, Frederic W. Stamler, M.D., Richard D. Liechty, M.D., and Elmer L. De Garvin, M.D. 16
Metcalf, W. K., M.D., D. J. Moffatt, M.B., Ch.B., D. A. Griffiths, M.B., Ch.B., and A. W. Jacobs, M.A., Audiovisual techniques in teaching of anatomy: television .. 26
Mick, David L., Ph.D., Thomas D. Gartin, M.D., and Keith R. Long, Ph.D., Case report: occupational exposure to insecticide naled 395

Midgut, Malrotation of, Joseph A. Cox, M.D., and Robert T. Soper, M.D. 317
Moeller, William S., M.D., Richard A. Truax, M.D., and Garfield Tourney, M.D., Medical approach to male homosexuality 397
Moffatt, D. J., M.B., Ch.B., D. A. Griffiths, M.B., Ch.B., A. W. Jacobs, M.A., and W. K. Metcalf, M.D., Audiovisual techniques in teaching of anatomy: television... 26
Month in Washington 7, 78, 153, 230, 305, 382, 555, 618
Morrissey, Wm. J., M.D., and Hubert C. Peterson, M.D., Primary adenocarcinoma of the jejunum: report of case 696
Morrow, Andrew G., M.D., Prosthetic replacement of mitral valve 42
Mungerson, Gerald W., Hospital administration and medical staff: working together for innovation 311

Neurologic abnormalities complicating severe renal disease, Robert L. Rodnitzky, M.D. 176
New approach to venous thrombosis (editorial) 713
New method for control of immunologic problems from Rh-incompatible pregnancy, Charles A. White, M.D. . 13
New pamphlet explains AMA to public 274
Newer concepts of evaluation of cardiac function, William W. Parmley, M.D., and Edmund H. Sonnenblick, M.D. 269
Nicknish, Stephen P., M.D., and Carl W. White, M.D., Porphyria: the little mimic, an interesting case with general review 821
Norris, A. S., M.D., Physician, marihuana and reason ... 623

Obstetric patient, High risk (editorial) 829
Oculoglandular tularemia: case report, Rodney A. Anderson, M.D. 21
Officers and Committees of Iowa Medical Society, 1970-1971 533

Paraplegic patients by localized cooling of spinal cord, Treatment of, Gaston J. Acosta-Rua, M.D. 326
Parent-child relationship, An ideal (editorial) 33
Parents and teenagers (editorial) 642
Parkinson's disease (a year's experience with 20 patients), L-Dopa therapy in, R. W. Fincham, M.D., and D. A. Decker, Jr., M.D. 755
Parmley, William W., M.D., and Edmund H. Sonnenblick, M.D., Newer concepts of evaluation of cardiac function 269
Pentazocine, Roger K. Ferguson, M.D. 112
Perforation of infant rectum (editorial) 409
Peripheral blood response to thyrotoxicosis, D. L. Landstrom, M.D., H. E. Hamilton, M.D., and R. F. Sheets, M.D. 183
Personals 59, 129, 209, 285, 359, 424, 597, 657, 725, 784, 840
Peterson, Hubert C., M.D., and Wm. J. Morrissey, M.D., Primary adenocarcinoma of the jejunum: report of case 696
Physician, marihuana and reason, A. S. Norris, M.D. ... 623
Porphyria: the little mimic, an interesting case with general review, Carl W. White, M.D., and Stephen P. Nicknish, M.D. 821
Positive side, On (editorial) 578
Possible agent in the transmission of Crohn's disease and its similarity to sarcoidosis, D. A. Glomset, M.D. (editorial) 773
Possible traumatic rupture of aortic valve, bacterial endocarditis and bilateral coronary embolism, Gerald J. Shirk, B.S., and Michael E. Korns, M.D. 180
Preceptors, College of medicine recognizes 241
Prepartum female with acute symptoms of hypertension and uremia, Diagnosis and management of, Kennedy C. Fawcett, M.D., John Sibley, M.D., and David Wall, M.D. 570
Prescribing of drugs in thirty-day supplies 115
President's address—Medicine's survival in seventies, W. M. Krigsten, M.D. 443
President's Page 32, 106, 186, 262, 332, 404, 448, 582, 640, 683, 744. 798
Prevention of urinary infection in patients with indwelling catheters, Joseph D. Schmidt, M.D. 815
Primary adenocarcinoma of the jejunum: report of case, Hubert C. Peterson, M.D., and Wm. J. Morrissey, M.D. 696
Problems of obesity (editorial) 410
Proceedings of 1970 Sessions of House of Delegates, Iowa Medical Society 449
Proctoscopic exam (editorial) 643
Program, IMS 1970 annual meeting 157
Prosthetic replacement of mitral valve, Andrew G. Morrow, M.D. 42
Psychiatric and legal aspects of drug use and abuse..... 31

Recinos, P. R., M.D., N. P. Rossi, M.D., and J. L. Ehrenhaft, M.D., Tuberculosis and bronchogenic carcinoma. 255
Recognition of pulmonary embolism, James K. Alexander, M.D. 114
Reference Committee Reports 516
Report of IMS Judicial Council 453
Reports of Officers 450
Reports of Special Committees 466
Reports of Standing Committees 454
Report of Treasurer 452
Reproductive factors associated with radiotherapy of malignant lymphomas, Donna L. Sooby, Ph.D., Herbert L. Jackson, Ph.D., and A. Curtis Hass, M.D. 636
Resolutions 506
Respiratory allergy in Iowa, Evaluation and treatment of, Hal B. Richerson, M.D., Paul M. Seebohm, M.D., and J. Montgomery Smith, M.D. 559
Rh-incompatible pregnancy, New method for control of immunologic problems from, Charles A. White, M.D. . 13
Richerson, Hal B., M.D., Paul M. Seebohm, M.D., and J. Montgomery Smith, M.D., Evaluation and treatment of respiratory allergy in Iowa 559
Rodnitzky, Robert L., M.D., Neurologic abnormalities complicating severe renal disease 176
Rossi, N. P., M.D., P. R. Recinos, M.D., and J. L. Ehrenhaft, M.D., Tuberculosis and bronchogenic carcinoma. 255
Rubella program—study in fulfillment, In the Public Interest facing p. 582
Rubella, Successful efforts (editorial) 577
Rubella vaccines, Alfred Healy, M.D. 828
Rupture of left subclavian artery and fatal hemorrhage in patient with multiple neurofibromatosis, Robert M. Cardelli, M.D., and William F. McCormick, M.D. ... 24

Sales and use taxes payable by physicians 48
Scanlon, Unveil painting of 403
Schmidt, Joseph D., M.D., Prevention of urinary infection in patients with indwelling catheters 815
Sedlacek, Richard L., M.D., and Kingsley B. Grant, M.D., Uterus didelphys with adenocarcinoma in one fundus—case report 324
Seebohm, Paul M., M.D., Hal B. Richerson, M.D., and J. Montgomery Smith, M.D., Evaluation and treatment of respiratory allergy in Iowa 559
Seven-year review of maternal and perinatal deaths, Madelene Donnelly Healy, M.D. 329
Sex and single student (editorial) 34
Sex education, AMA film on 31
Sheets, R. F., M.D., D. L. Landstrom, M.D., and H. E. Hamilton, M.D., Peripheral blood response to thyrotoxicosis 183
Shirk, Gerald J., B.S., and Michael E. Korns, M.D., Possible traumatic rupture of aortic valve, bacterial endocarditis and bilateral coronary embolism 180
Shoji, Takeshi, M.A., Edna Fine, M.S.W., Richard L. Jenkins, M.D., and Robert Gants, M.A., Interrupting family cycle of violence 85
Sibley, John, M.D., David Wall, M.D., and Kennedy C. Fawcett, M.D., Diagnosis and management of prepartum female with acute symptoms of hypertension and uremia 570
Smith, J. Montgomery, M.D., Hal B. Richerson, M.D., and Paul M. Seebohm, M.D., Evaluation and treatment of respiratory allergy in Iowa 559
Sonnenblick, Edmund H., M.D., and William W. Parmley, M.D., Newer concepts of evaluation of cardiac function 269
Sooby, Donna L., Ph.D., Herbert L. Jackson, Ph.D., and A. Curtis Hass, M.D., Reproductive factors associated with radiotherapy of malignant lymphomas 636
Soper, Robert T., M.D., and Joseph A. Cox, M.D., Malrotation of midgut 317
Spaceship earth, Daniel F. Crowley, M.D. (editorial)... 334
Stamler, Frederic W., M.D., Richard D. Liechty, M.D., and Elmer L. De Garvin, M.D., Metastisizing thyroid cancer ten years after radioactive iodine treatment for hyperthyroidism 16
State Department of Health 53, 116, 204, 277, 353, 414, 590, 646, 717, 750, 810
Successful rubella efforts (editorial) 577
Sunbathing, Use caution in (editorial) 581
Sunderbruch, J. H., M.D., Inaugural remarks 446
Supplemental Reports of Special Committees 503
Supplemental Reports of Standing Committees..... 493
Supplemental Reports, Board of Trustees 479
Surgical division established, New 351
Surgical management of diverticulitis (editorial) 406
Survey on small community practice 557
Swanson, L. W., M.D., Community hospital experience with emergency cardiac resuscitation 569
Sybers, Wm. A., M.D., and Wm. W. Jones, M.D., Delayed spontaneous rupture of a splenic hemangioma... 706

Taylor, James C., M.D., Idiopathic thrombocytopenic purpura in childhood: approach to therapy 94
Taylor, John R., M.D., and Maurice W. Van Allen, M.D., Indications for use of anticoagulants in stroke syndromes 767
Taylor, John R., M.D., Vasodilators in prevention and treatment of ischemic stroke 258
Tetanus and polio immunizations, Marion E. Alberts, M.D. (editorial) 336
Tetralogy of Fallot, Robert E. Durnin, M.D., Dorothy A. Ehmke, M.D., and John B. Flege, M.D. 171
Tetralogy of Fallot, James R. Malm, M.D. 411
Therapeutic abortions at University Hospitals, 1951-1969, with emphasis on current trends, David W. Wetrich, M.D., and Lowell R. Hughes, M.D. 691
Tourney, Garfield, M.D., Richard A. Truax, M.D., and William S. Moeller, M.D., Medical approach to male homosexuality 397

Treatment of traumatic paraplegic patients by localized cooling of spinal cord, Gaston J. Acosta-Rua, M.D. ... 326
Trends in use of forceps (editorial) 108
Truax, Richard A., M.D., William S. Moeller, M.D., and Garfield Tourney, M.D., Medical approach to male homosexuality 397
Tuberculosis and bronchogenic carcinoma, N. P. Rossi, M.D., P. R. Recinos, M.D., and J. L. Ehrenhaft, M.D. .. 255
Tuberculous peritonitis: use of hook needle biopsy, David F. Gordon, M.D. 819

Under study, foundation for medical care, In the Public Interest facing p. 670
University Hospitals Drug Letter 112, 339, 583, 828
U. of I. Cardiology Division offers new program 328
University of Iowa College of Medicine: 100 years ago, William B. Bean, M.D. 237
Urge ECG to detect asymptomatic infarcts (editorial) . 337
Urinary infection in patients with indwelling catheters, Prevention of, Joseph D. Schmidt, M.D. 815
Use and misuse of psychotropic drugs 98
Use caution in sunbathing (editorial) 581
Use of anti-arrhythmic agents other than digitalis, Leonard S. Dreifus, M.D. 192
Uterus didelphys with adenocarcinoma in one fundus—case report, Kingsley B. Grant, M.D., and Richard L. Sedlacek, M.D. 324

Van Allen, Maurice W., M.D., and John R. Taylor, M.D., Indications for use of anticoagulants in stroke syndromes 767
Vasodilators in prevention and treatment of ischemic stroke, John R. Taylor, M.D. 258

Wall, David, M.D., Kennedy C. Fawcett, M.D., and John Sibley, M.D., Diagnosis and management of prepartum female with acute symptoms of hypertension and uremia 570
Wetrich, David W., M.D., and Lowell R. Hughes, M.D., Therapeutic abortions at University Hospitals, 1951-1969, with emphasis on current trends 691
What is air pollution? (editorial) 408
What troubles troubed youth (editorial) 187
When is mastoidectomy necessary? (editorial) 266
White, Carl W., M.D., and Stephen P. Nicknish, M.D., M.D., Porphyria: the little mimic, an interesting case with general review 821
White, Charles A., M.D., New method for control of immunologic problems from Rh-incompatible pregnancy. 13
Woman's Auxiliary News 55, 123, 199, 281, 356, 420, 594, 652, 720, 780, 836
Worldwide regulations regarding preventive medicine need strengthening (editorial) 191

Youth, Profitable programs for (editorial) 579

Index to Advertisers

American Cancer Society 846B
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Casualty Indemnity Exchange 811
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Seven-Up Bottlers of Iowa 847
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Iowa Medical Miscellany

(Continued from page 809)

Last of the Foundation for Medical Care briefings occurred November 18 in Des Moines. Society President J. H. Sunderbruch, M.D., and Board Chairman K. E. Lister, M.D., have made 16 presentations on the Foundation concept since September 8. The informational series, requested by the 1970 House of Delegates, has been under the auspices of the Iowa Medical Society and the Scanlon Medical Foundation/IMS. Society officers must now decide the next appropriate step in the consideration of this idea.

* * *

Sixty-five county medical societies have elected to participate in the new dues billing and collecting program being offered by the IMS.

* * *

The Psychiatric Hospital in Iowa City is observing its 50th anniversary this year. The hospital opened in 1920 and was the second building constructed on the present health center campus. It was the second psycopathic hospital in the nation to be affiliated with a major university.

* * *

Society meetings in December: Joint Committee—Psychiatric Care Subcommittee & Iowa Bar Liaison—Dec. 2; Committee on Medical Review —Dec. 9; Committee on Legislation—Dec. 9; Study Committee on MD-DO Education—Dec. 9; Board of Trustees—Dec. 15 and 16.

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